

FILIAL THERAPY WITH IMMIGRANT KOREAN PARENTS
IN THE UNITED STATES

Mi-Kyong Lee, B.H.E., M.H.E.

Dissertation Prepared for the degree of
DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

August 2002

APPROVED:

Garry L. Landreth, Major Professor and Chair

Michael, Mahoney, Minor Professor

Henry, Harris, Committee Member

Michael Altekruze, Chair of the Department of
Counseling, Development, and Higher
Education

M. Jean Keller, Dean of the College of Education

C. Neal Tate, Dean of the Robert B. Toulouse
School of Graduate Studies

Lee, Mi-Kyong, Filial Therapy with Immigrant Korean Parents in the United States, Doctor of Philosophy (Counseling), August 2002, 121 pp. 25 tables, references, 86 titles.

This study was designed to determine the effectiveness of filial therapy training in: (a) increasing immigrant Korean parents' empathic behavior with their children; (b) increasing immigrant Korean parents' acceptance level toward their children; and (c) reducing immigrant Korean parents' stress related to parenting.

The experimental group, consisting of 17 immigrant Korean parents in the United States, received 10 weekly 2-hour filial therapy training sessions and participated in weekly 30-minute play sessions with one of their children. The control group, consisting of 15 immigrant Korean parents in the United States, received no treatment during the ten weeks.

All the parents were videotaped playing with their child before and after the training as a means of measuring change in empathic behavior. The two written self-report instruments completed for pretesting and posttesting purposes were the Porter Parental Acceptance Scale and the Parenting Stress Index.

Analyses of covariance revealed that the immigrant Korean parents in the experimental group had significant changes in 10 of 12 hypotheses, including (a) a significant increase in their level of empathic interactions with their children; (b) a significant increase in their attitude of acceptance toward their children; and (c) a significant reduction in their level of stress related to parenting.

This study supports the use of filial therapy for promoting the parent-child relationship in immigrant Korean families in the United States. Filial therapy helps

immigrant Korean parents to be therapeutic agents for their children. It helps them regain their own power as parents and restore positive relationships with their children.

Copyright by
Mi-Kyong Lee
2002

ACKNOWLEDGEMENTS

I am grateful to Dr. Garry Landreth, my professor, for his commitment to teaching and to my learning. I also appreciate his constant encouragement and patient consultation throughout my learning experience. I wish to express my gratitude to Dr. Michael Mahoney, my minor professor, and Dr. Henry Harris for their encouragement to be myself and to trust myself. I also appreciate Dr. Sue Bratton and Dr. Lessie Perry for their insightful guidance in working with children and families. I would like to express special thanks to Dr. Jae-Yeon Lee and Dr. Young-Hee Choi in Korea for their love and care in completing my Ph.D. degree in the States.

This dissertation is dedicated to my parents, Jang-Hyung Lee and Sun-Hee Jeon, who have been always with me, emotionally and spiritually. Additionally, I would like to extend my appreciation to my parents and families as well as friends for their faithful support and encouragement. Lastly, I want to thank my Lord for His continuous love and guidance, which made me who I am today.

TABLE OF CONTENTS

| | |
|---|-------------|
| ACKNOWLEDGEMENTS | Page iii |
| LIST OF TABLES | v |
| CHAPTER | |
| I. INTRODUCTION | 1 |
| Statement of the Problem | 5 |
| A Review of the Literature | 6 |
| Influences of Confucianism on the Traditional Korean Family | 6 |
| Immigrant Korean Families in the United States | 12 |
| Filial Therapy | 19 |
| II. METHODS AND PROCEDURES | 37 |
| Definition of Terms | 37 |
| Hypotheses | 40 |
| Limitations | 41 |
| Instruments | 42 |
| Measurement of Empathy in Adult-Child | 42 |
| Porter Parental Acceptance Scale | 44 |
| Parenting Stress Index | 46 |
| Selection of Subjects | 47 |
| Collection of Data | 50 |
| Ten-Week Training Model | 51 |
| Facilitator | 54 |
| Statistical Analysis | 54 |
| III. RESULTS AND DISCUSSION | 57 |
| Results | 57 |
| Discussion | 75 |
| Summary | 94 |
| Recommendations | 95 |
| Concluding Remarks | 96 |
| APPENDIX | 98 |
| A. Research Information and Consent Forms | 98 |
| B. Measurement of Empathy in Adult-Child Interaction | 102 |
| C. Letter of Permission to Use Porter Parental Acceptance Scale | 104 |
| D. Porter Parental Acceptance Scale | 106 |
| REFERENCES | 113 |

LIST OF TABLES

| Table | Page |
|--|------|
| 1. Interrater reliability for Measurement of Empathy in Adult-Child Interaction | 55 |
| 2. Mean total scores for the Measurement of Empathy in Adult Child Interaction (MEACI) | 58 |
| 3. Analysis of covariance data for the mean total scores on the Measurement of Empathy in Adult Child Interaction (MEACI) | 58 |
| 4. Mean scores for the MEACI subscale: Communication of Acceptance | 59 |
| 5. Analysis of covariance data for the mean scores for the MEACI subscale: Communication of Acceptance | 60 |
| 6. Mean scores for the MEACI subscale: Allowing the Child Self-Direction | 61 |
| 7. Analysis of covariance data for the mean scores on the MEACI subscale: Allowing the Child Self-Direction | 61 |
| 8. Mean scores for the MEACI subscale: Involvement | 62 |
| 9. Analysis of covariance data for the mean scores on the MEACI subscale: Involvement | 63 |
| 10. Mean total scores for the Porter Parental Acceptance Scale (PPAS) | 64 |
| 11. Analysis of covariance data for the mean total scores on the Porter Parental Acceptance Scale (PPAS) | 64 |
| 12. Mean scores for the PPAS subscale: Respect for the Child's Feelings and Right to Express Themselves | 65 |
| 13. Analysis of covariance data for the mean scores on the PPAS subscale: Respect for the Child's Feelings and Right to Express Themselves | 66 |
| 14. Mean scores for the PPAS subscale: Appreciation of the Child's Unique Makeup | 67 |
| 15. Analysis of covariance data for the mean scores on the PPAS subscale: Appreciation of the Child's Unique Makeup | 67 |
| 16. Mean scores for the PPAS subscale: Recognition of the Child's Need for Autonomy | 68 |
| 17. Analysis of covariance data for the mean scores on the PPAS subscale: Recognition of the Child's Need for Autonomy | 69 |
| 18. Mean scores for the PPAS subscale: Unconditional Love | 70 |
| 19. Analysis of covariance data for the mean scores on the PPAS subscale: Unconditional Love | 70 |
| 20. Mean total scores for the Parenting Stress Index (PSI) | 71 |
| 21. Analysis of covariance data for the mean total scores on the Parenting Stress Index (PSI) | 71 |
| 22. Mean scores for the PSI subscale: Parent Domain | 72 |
| 23. Analysis of covariance data for the mean scores on the PSI subscale: Parent Domain | 73 |
| 24. Mean scores for the PSI subscale: Child Domain | 74 |
| 25. Analysis of covariance data for the mean scores on the PSI subscale: Child Domain | 74 |

CHAPTER I

INTRODUCTION

The population of immigrant Koreans in the United States has steadily increased since the enactment of the 1965 Immigration Act (Hurh, 1998; Min, 1995 & 1998). Since family migration was encouraged by the Act, immediate family members and other relatives who had already settled in the United States invited their family members and relatives in Korea to the new country (Hurh, 1998). Therefore, Korean immigrants became the second largest Asian immigrant group in the US in the 1970s and 1980s despite their short immigration history (Min, 1995 & 1998).

Immigration is a process of uprooting, adjusting, and rerooting for any immigrant group (Hurh, 1998). They experience a certain degree of culture shock, adjustment stress, and sociocultural disruption, caused mainly by a distinctively different culture and language, limited English proficiency, and unique physical characteristics (Chu, 1993; Hong & Hong, 1996; Hurh, 1998; Kim & Miura, 1999; Kim, Sawdy, & Meihoefer, 1982). Immigrant Korean families are also caught between their traditional values and new systems, and they struggle to develop a happy medium by blending the two (Hurh, 1998). These problems have been serious for Korean American children because they are caught in transition as they exist between their different worlds of school and home (Chu, 1993).

In the process of acculturation, an intergenerational gap between immigrant Korean parents and their children develops. Immigrant Korean parents experience

uncertainty and unfamiliarity, so they often fail to provide for their children consistent parenting (Ryu & Vann, 1992). They have difficulty teaching their children how to live and succeed and to deal with the conflicts in a new and different culture (Kim et al., 1982; Ryu & Vann, 1992). Moreover, due to the influences of Confucianism, Korean parents expect their children to respect them and to show unconditional obedience toward themselves (Kim & Choi, 1994). They complain that their children have become Americanized, selfish, disobedient, and materialistic, and feel that their authority is threatened by the child's increased use of English (Kim et al., 1982; Rhee, 1996).

On the other hand, for many Korean American children there is a conflict between Korean traditional values of filial piety and patriarchy and Westernized values of individualism and self-assertion (Rhee, 1996). They feel alienated and experience intense conflict with their parents as well as identity conflict (Hong & Hong, 1996). With their parents' high expectations and demands regarding their academic work as well as their parents' willingness to sacrifice themselves for their children, Korean American children may feel guilt and worthlessness as well as helplessness when failing to satisfy their parents' needs (Hurh, 1998; Hong & Hong, 1996; Lee-Oh, 1994). Therefore, a parent-child conflict occurs. Rhee (1996) contended that the most common crisis facing Korean American children results from conflict between what they really want and what their parents want from them. Rhee also added that the difference in degree of acculturation between Korean American parents and their children is the major source of conflict and suggested a family-centered approach in dealing with parent-child problems.

In the traditional Korean family, the mother has the primary responsibility of maintaining the psychological well-being of her children (Kim & Choi, 1994; Rohner &

Pettengill, 1985). In her role as emotional provider and healer, the Korean mother maintains close bonds with the children and meets this essential psychological need. Korean mother-child relationships are the essence of chong (Choi, Kim, & Choi, 1993; Kim & Choi, 1994). Chong is the psychological connotations of an important affective bond, and can be narrowly translated as human affection, but its meaning is broader. Mo chong means a mother's (mo) love or affection (chong) for the children. Mo chong is more than deep love and generosity but includes acceptance, embracement, forbearance, or even overlooking mistakes made by the children (Kim & Choi, 1994). Unconditionality, empathy, care, sincerity, sacrifice, and shared experience are associated with mo chong (Choi, Kim, & Choi, 1993). In a mo chong relationship, a mother tries to understand from the child's perspective and empathically related the child's disappointments. This accepting affective bond is a powerful force that shapes behavior (Kim & Choi, 1994).

Filial therapy, which trains parents to be therapeutic agents in their children's lives, (Guerney, 1964; Landreth, 1991), is a culturally sensitive intervention for the Korean American family. Koreans value harmonious family relationships due to the influences of Confucianism (Min, 1998). Filial therapy emphasizes the parent-child relationship as the facilitator of mental health in children. It helps parents to be sensitive, to understand, and to accept their children's needs within a nonjudgmental and accepting environment (Landreth, 1991). Moreover, Rhee (1996) suggested that parents must learn how to allow their children to express their different opinions, and understand how their children are caught up and struggling in two different cultures. In filial therapy, parents are helped to understand and accept their children's needs in a nonjudgmental manner.

In filial therapy, parents are taught to be the primary change agents for their own children; parents learn to be aware of their children's emotional needs, and interact effectively on an emotional level with their children (Landreth, 1991). The parents are helped to support their children in expressing the meaning of their experiences from the children's own perspective; this process results in greater parental acceptance of children's feelings. The parents give their children their full attention, concentration, and empathy (Moustakas, 1959).

Filial therapy is an innovative therapeutic model that uses parents as the primary change agents to develop positive parent-child relationships (Landreth, 1991). The relationship between parent and child is a determinant of healthy psychosocial development in children. In filial therapy parents are able to become the therapeutic agents in their children's lives by strengthening the naturally existing parent-child bond, hence the term filial therapy (Landreth & Lobaugh, 1998). Parents have a uniquely powerful impact on children because of this natural emotional bond between parent and child (Guerney, 1964). Filial therapy enables parents to become active allies in the therapeutic process, rather than passive observers, co-clients, or even antagonists (Guerney, 1983). The filial therapist conveys faith in parents' abilities to grow in understanding and acceptance of the child and to have positive impact on the child's development (Landreth, 1991). Strengthening existing parent-child bonds and conveying faith in the parents' abilities to grow can provide parents with powerful relationship-building skills. Therefore, the filial therapy process empowers parents to facilitate healthy development of their children.

Filial therapy has been shown to be an effective parent training model (Andronico & Guerney, 1967; Boll, 1972; Bratton & Landreth, 1995; Costas & Landreth, 1999; Dematatis, 1981; Ginsberg, 1976; Glass, 1986; Guerney & Guerney, 1989; Guerney & Stover 1971; Lahti, 1993; Landreth & Lobaugh, 1998; Lebovitz, 1983; Oxman, 1971; Payton, 1980; Sensue, 1981; Smith, 2000; Stollak, 1969; Stover & Guerney, 1967; Sywulak, 1979; Tew, 1997). These studies have demonstrated that parents are able to be therapeutic agents for their own children, that parents' relationships with their own children can be improved, and that children's adjustment can be enhanced as a result of filial therapy training. In addition, filial therapy has been demonstrated as an effective treatment model with parents in different ethnic groups such as Korean, Chinese, and Native American parents (Chau, 1996; Glover & Landreth, 2000, Jang, 2000; Yuen, 1997).

Statement of the Problem

The problem with which this investigation is concerned is that of determining the effectiveness of filial therapy as a method of prevention and intervention for immigrant Korean parents and their children. Specifically, this study is designed to determine the effectiveness of filial therapy in: (a) increasing immigrant Korean parents' communication of acceptance with their children; (b) increasing immigrant Korean parents' allowance of child self-direction; (c) increasing immigrant Korean parents' involvement in child's play; (d) increasing immigrant Korean parents' acceptance of their children; and (e) reducing immigrant Korean parents' stress related to parenting.

A Review of Related Literature

The following review is a synthesis of theoretical constructs and research related to three major areas: (a) Influences of Confucianism on the traditional Korean family; (b) immigrant Korean families in the United States; and (c) filial therapy.

Influences of Confucianism on the Traditional Korean Family

Relationship focused. Confucianism has been the dominant ethic for governing human relationships in Korea for more than 500 years (Kim & Choi, 1994; Lee, 1996; Min, 1998; Yi, 1993). It is almost impossible to understand Korean traditional culture and its family system without understanding the influence of Confucianism (Min, 1998; Yi, 1993). The main characteristic of Confucianism is its focus on human relationships (Min, 1998). Individuals are taught to pursue harmonious social relationships. Five interpersonal relationships form the basis of Confucius' principles on the duties and obligations of each individual (Min, 1998). These relationships include the relations between parents and children, king and people, husband and wife, older brother and younger brother, and friends (Min, 1998; Yi, 1993).

The most important relationship in Confucianism is the father-son relationship, which is the hierarchy central to all relationships (Kim & Choi, 1994; Yi, 1993). The father-son relationship occupies a more important position than any other relationship, such as husband-wife, elder and younger brothers, and friends (Yi, 1993). Moreover, it implies that the father is only a symbolic head in the Korean family, and that the son succeeds the role to connect the lineage from ancestors to descendants (Kim & Choi, 1994; Yi, 1993).

The distinguished role between a husband and a wife. Confucianism emphasizes clearly different roles for husband and wife (Min, 1995 & 1998; Yi, 1993). Throughout history in the traditional Korean family, the husband was considered to be the primary breadwinner, the decision-maker, and the educator of the sons, as well as the head of the family and leader in ancestor worshipping. The wife was expected to obey her husband, to devotedly serve him and his family members, to perpetuate her husband's family lineage by producing children (especially sons) to nurture the children, to teach a daughter how to be a wise mother and good wife, and to manage households and maids (Min, 1995 & 1998, Yi, 1993). The husband and the wife did not interfere with each other and kept their role boundaries between them (Yi, 1993).

In earlier Korean history, this special division was maintained in the spatial and psychological domain (Yi, 1993). Since the traditional Korean house was divided into two sectors, the outside sector for the husband and the inside sector for the wife, the husband was called bagatyangban, and the wife was referred to as anae. The term bagatyangban represents literally the person who is exterior, and the term anae means literally the person who is interior. Moreover, communication between the husband and the wife was by indirect means. Generally, a maid mediated the words between the husband and the wife. In traditional Korean society indirect communication was acknowledged (Yi, 1993).

Socialization differences between boys and girls. In a traditional Korean family, boys and girls were expected to be differently socialized (Yi, 1993). Sons learned Korean and Chinese literacy and rituals from their grandfather or a relative acknowledged as being well educated among all the relatives. A father did not teach his son because the

father could not control his temper due to the attached relationship. The son was educated by observing adult behaviors and attitudes in life situations (Yi, 1993). The son was expected to become the head person serving ancestor worship and to be the leader of the family. When a son did not obey the family rules or behaved badly, he was made to turn his trousers up to the knee and was flogged on a wooden pillow. The son was required to find a rod before being flogged, and the adult became calmer during this waiting time. The waiting time prevented the adult from harming the child out of rage. When the rod was prepared, the adult explained to the child the reason why he was to be flogged. This reasoning process as a role of education helped the adult to calm his temper and encouraged the child to think about his mistakes (Yi, 1993). Girls learned Korean literacy, letter writing, and household management, as well as how to be a wise mother and good wife. Since the traditional Korean family was based on patriarchy and patrilineage, a son was considered more valuable and given more power than a daughter (Min, 1998).

The different and complementary parenting roles. In the traditional Korean family, parental roles were strictly differentiated by gender as directed by Confucianism (Kim & Choi, 1994; Rohner & Pettengill, 1985; Yi, 1993). The contrast in parental roles is best summarized in the popular Korean phrase om bu ja mo (Rohner & Pettengill, 1985). Literally, the phrase means a strict father and a benevolent mother (Rohner & Pettengill, 1985), a stern male and a nurturant female, or a strict father and a kind mother (Yi, 1993). Om bu ja mo states a positive and complementary cultural perception to Koreans (Kim & Choi, 1994; Rohner & Pettengill, 1985). Typically, the father as stern disciplinarian was more concerned with self-regulation of the child than expression of

feelings, and the mother as kind and affectionate protector was more concerned with the child's emotional stability than with achievement. These differentiated parenting roles placed the father in the role of a moralistic educator rather than a psychological agent (Yi, 1993).

Besides having a symbolic role in a family, the father represented a link between the family and the outer world (Kim & Choi, 1994). Through the father, children were linked across time through his lineage and across space through his position in a community. It was the father's responsibility to maintain, propagate, and elevate the position of the family. During the decision making process, he had to simultaneously consider influences of his decisions on the children, on the family, on the lineage, and on the community. Thus, wisdom and foresight were essential ingredients in his decision making process (Kim & Choi, 1994).

The psychological and physical well-being of a child were considered the primary responsibility of the mother (Kim & Choi, 1994). According to Yu (1981, 1984, & 1985), in traditional Korean society, mothers believed that children needed more than just their milk. They believed that symbolic dewes coming down from a mother to her child were necessary as a symbolic representation of an intrinsic bond between mothers and their children. The maternal dewes implied a mother's faithful belief in the invisible but powerful bond between a mother and her child (Yu, 1984, 1985, & 1985).

Maternal dewes were considered to have special healing powers (Kim & Choi, 1994). A mother would wash the infant with water with which she had washed herself when an infant got jaundice. A mother's spittle was used as first aid to a child's cut or scrape wound. A mother's hair was often used to remove a child's warts. A mother's skirt

became a huge bandage for a baby that developed a rash. People believed that the rash would disappear if the baby fell asleep in the skirt (Kim & Choi, 1994).

There is another important concept representing maternal care: T'aekyo (Lee, 1993; Yu, 1984). T'aekyo were guidelines that outlined dos and do nots for pregnant women. It represented the belief that a mother's experience during her pregnancy would directly impact on the baby inside her womb and leave long lasting imprints on the child. Therefore, t'aekyo, the traditional form of prenatal care, stressed a psychological connection between a mother and an unborn child in her womb (Yu, 1984).

Because of this strong sense of relatedness between a mother and child, Korean mothers consider their children as extensions of themselves (Kim & Choi, 1994). Korean mothers view their children's accomplishments to be their own achievements. They satisfy and fulfill their unaccomplished dreams and goals through their children. In this way, a Korean mother's personhood is fused with that of her children, and she does not pursue her own independent identities and goals. Her significant maternal role, however, does not imply greater maternal sensitivity to the needs of the individual child (Choi, 1998; Kim & Choi, 1994).

Children's education. Confucianism emphasizes children's education (Hurh, 1998 & Lee, 1996; Min, 1995 & 1998, Yi, 1993). Koreans believed that the fetus, from the time of conception, should be educated (Lee, 1996). This belief placed great emphasis on prenatal education. At a very early age children learned filial loyalty for parents and ancestors, ethics, propriety and gender roles (Lee, 1996; Yi, 1993).

Historically, Koreans had great faith in education as the main way to gain social mobility (Hurh, 1998; Min, 1995 & 1998). Korean parents viewed their children's

education and careers as being equally important, and they were willing to sacrifice their own needs to provide their children with a better education (Min, 1995). However, this zeal for children's education now causes many social problems such as parents' heavy financial burdens, children's excess mental pressure, and test-oriented high school education (Min, 1998).

Child's role. Confucianism applied to the Korean family system and social life emphasizes children's one-sided obedience to and respect for parents and other adults (Kim & Choi, 1994; Min, 1998; Yi, 1993). Kim and Choi (1994) described five duties of children toward their parents as they mature: obeying, attending, supporting, comforting, and honoring. First, children must respect their parents' opinions and authority. Second, they must take care of their parents' every need. Third, they must provide materialistic comforts for the parents. Forth, they must create psychological ease and comfort by not worrying parents. Finally, they must honor their parents' achievements, fulfill their intentions, complete their undertakings, and sustain their social networks even after their parents pass away. In these five duties, attending and supporting are concerned with physical comfort, but comforting is more concerned with psychological comfort (Kim & Choi, 1994). The son in a family, especially, was expected to provide materialistic comforts for the parents and psychological care in their old age, and to perform ceremonial duties of ancestral worship after their parent's death (Kim & Choi, 1994; Min, 1998; Yi, 1993).

Immigrant Korean Families in the United States

General characteristics of immigrant Korean. Korean immigration to the United States started with three Koreans who claimed to be political refugees in 1885 (Mangiafico, 1988). More than 7,200 Koreans came to Hawaii to work on sugar plantations between 1903 and 1905 (Min, 1995). The official count of Korean immigrants in the 1990 census was close to 800,000 (Min, 1995).

Immigrant Korean share several common characteristics: (a) they comprise a homogenous group in culture and historical experiences (Hurh, 1998; Min, 1995 & 1998); (b) they are Christian, generally, Protestants (Hurh, 1998; Mangiafico, 1988; Min, 1995 & 1998); and (c) they engage in small business (Hurh, 1998; Min, 1995 & 1998). Korea is a small and culturally homogeneous country (Min, 1995 & 1998). Koreans speak one language. All immigrant Koreans can understand Korean language newspapers and Korean TV programs. Because of Korea's homogeneity, the lack of diversity provides Koreans with Korean ethnic attachment and solidarity.

Immigrant Koreans also maintain strong ethnic attachment by affiliating with Korean ethnic churches (Mangiafico, 1988; Min, 1995 & 1998). The Korean ethnic church has played a central role in the Korean American community by providing not only spiritual fellowship but also ethnic fellowship, cultural identity, and social services (Hurh, 1998). The Korean ethnic church has historically been the best-established social, cultural, and educational center for Korean immigrants in the US. The church has also traditionally functioned as a reception center for newly arrived immigrants. The church has been the most inclusive and accessible social institution for Korean immigrants regardless of gender, age, or socioeconomic status. The Korean ethnic church provides

immigrant Koreans with frequent and regular opportunities for both informal and formal social gatherings. The immigrants gather with close friends and relatives as well as having the opportunity to make new friends outside their family circle. The children maintain Korean cultural traditions (Min, 1998). They participate in language and other cultural programs, learn traditional Korean values, and celebrate important Korean holidays with a variety of Korean food (Min, 1998). In this way, the Korean ethnic church satisfies the religious need for meaning, the social need for belonging, and the psychological need for comfort for Korean immigrants (Hurh, 1998).

Immigrant Koreans also share a common characteristic of concentration in small business (Hurh, 1998; Min, 1995 & 1998; Ryu & Vann, 1992). Language, culture, and especially educational credentials and occupational skills are not easily transferable from Korea to the US, and the segmented nature of the American labor market explains the concentration of Koreans in small business. Immigrant Korean are involved in several business specialties such as grocery, produce, liquor and dry cleaning services, as well as retail sales of Asian-imported manufactured goods (Min, 1998). The vast majority of Korean Americans work with their family members and fellow Koreans, speak the Korean language, and practice Korean customs (Min, 1998). In this way, small business enterprises contribute to maintaining Korean ethnic ties and ethnic solidarity.

Cultural homogeneity, high affiliation with immigrant Korean churches, and concentration in small businesses maintain and contribute to immigrant Koreans' strong ethnic attachment and solidarity. However, these characteristics hinder their assimilation into American society (Min, 1995). Immigrant Koreans have a low level of tolerance for cultural differences in the US. They are reluctant to learn English and American customs.

Since newly arrived immigrant Koreans tend to find jobs in Korean firms, they have little motivation to learn English. Moreover, by shopping at Korean ethnic specialty markets they lose opportunities to learn and use English and American customs. Therefore, immigrant Koreans have little opportunity for assimilation in mainstream USA (Min, 1995).

Hardships of first generation immigrant Korean parents. Cultural conflicts are the first hardships that immigrant Korean parents face. Adopting a completely new and very different culture is a serious obstacle for immigrant Korean families to overcome (Hong & Hong, 1996). Immigrant Korean families face new challenges, including social pressure to acquire a second language, psychological stress, financial burden, and increasing demands of adjustment and adaptation (Choi, 1998). Family conflicts begin to emerge when old problems and difficulties are exacerbated and become obvious as a result of the new stressful situations (Choi, 1998).

Since immigrant Koreans experience uncertainty about the appropriateness of their own values and norms and are unfamiliarity with the new culture's values and norms, they often fail to provide consistent parenting for their children. Moreover, this causes confusion and irritation in the children (Ryu & Vann, 1992). Choi (1998) found that immigrant Korean mothers suffered personal confusion and cultural confusion in their new environment. Since their position in the family was always as either someone's daughter, wife, or mother, they never considered themselves to be a single entity and as a result, they never developed a sense of personhood as individuals. This conflict and confusion causes fear of being misjudged and misinterpreted by people in the ambient

culture. This phenomenon tends to be exacerbated by stress evoking incidents in the process of child rearing and adjusting to a new culture (Choi, 1998).

Another hardship of immigrant Korean parents is the language barrier (Kim et al., 1982; Hong & Hong, 1996; Ryu & Vann, 1992). They often have low self-esteem because they can not speak English well, and their children are learning English faster than they are (Kim et al., 1982; Ryu & Vann, 1992). The child's increased learning and use of English is threatening to the parent's preferred authority structure for the family. The parent's continued use of Korean and lower proficiency in English can produce impatience, scorn, or embarrassment in the child (Kim et al., 1982). This can block opportunity for constructive communication between the parents and their children (Ryu & Vann, 1992).

Kim et al. (1982) contended that immigrant Korean parents have contradictory desires. Even though over 90 percent of all communication among family members continues to be in Korean, parents have high expectations for their child's academic success and career success in the American job market. However, the child's proficiency in English is strongly related to academic success in school. Therefore, contradictory needs of the parents block the emotional relationship between parents and their children (Ryu & Vann, 1992).

Lack of understanding of the American educational system is another difficulty of Korean immigrant parents. Ryu and Vann (1992) addressed two major differences between the Korean and American educational system. The Korean educational system is centralized and less participatory, whereas the American system is decentralized and stresses parental participation. Korean parents are accustomed to an educational system in

which authority of teachers is absolute, so they may feel uncomfortable in active participation in a PTA meeting. Moreover, the Korean system overwhelmingly emphasizes academics, while the American system emphasizes equally nonacademic areas such as sports. Therefore, differences between the two educational systems, coupled with language barriers of Korean parents, prohibit Korean parents from active participation in their children's education even if they desire participation (Ryu & Vann, 1992).

Hardships of second generation Korean American children. Language and cultural barriers are the first hardships of Korean American children. Chu (1993) contended that among Koreans in the US cultural conflicts have been most severe for Korean American children. They experience language as well as cultural conflict between their parent's native culture and American mainstream culture (Hong & Hong, 1996; Kim & Miura, 1999; Min, 1995; Rhee, 1996; Ryu & Vann, 1992). Most Korean American children cannot speak Korean fluently. The language barrier between Korean American parents and their children causes lack of communication, and consequently the children's problems are easily multiplied and overlooked (Hong & Hong, 1996).

Korean American children feel alienated and experience intense conflict with their parents as well as identify conflict (Hong & Hong, 1996). They have difficulty genuinely respecting their parents, who cannot teach them much about how to live and succeed in America (Ryu & Vann, 1992). This causes their parents to feel incompetent and inferior and to behave defensively. Korean American children have difficulty being proud of their Korean heritage (Ryu & Vann, 1992). They reject their own culture while

simultaneously feeling isolated and rejected by American students. Consequently their self-esteem is at risk (Hong & Hong, 1996; Kim & Miura, 1999; Ryu & Vann, 1992).

Hurh (1993) proposed that because of the young Korean American immigrant's bilingualism and bicultural socialization, they may eventually face critical psychosocial ambivalence. The ambivalence leads to an existential limbo, in which one perceives a marginal self-identity for oneself. If children identify with the marginal personality, they have negative resolution of tension and exhibit ambivalence about personal identity, inferiority complexes, hypersensitivity, social isolation, and feelings of powerlessness (Hurh, 1993).

The second struggle of Korean American children is the pressure they experience related to school work and parental sacrifice. Immigrant Korean parents put their children's academic success as their top priority (Hong & Hong, 1996; Min, 1995; Rhee, 1996). Korean children know what is expected of them in terms of their school work even without extensive communication from their parents (Hong & Hong, 1996). However, although a large number of Korean American students are academically successful, a significant proportion have problems in school and engage in various delinquent acts (Min, 1995). Cutting class, skipping school without notice, fighting, and running away from home are common problems of Korean high school students. Moreover, gang-related crimes have become the most serious juvenile problem in the immigrant Korean community (Min, 1995).

High parental expectations and demands for academic success cause feelings of guilt and worthlessness as well as helplessness when children are not able to satisfy their parents' wishes (Hong & Hong, 1996; Lee-Oh, 1994). Moreover, Korean American

parents are willing to sacrifice themselves to provide their children with better education, and their children witness their parents' immeasurable sacrifices (Hong & Hong, 1996; Min, 1995). The result is a developing a sense of guilt and obligation in Korean American children. They feel that they owe it to their parents to succeed in school and in their careers (Hong & Hong, 1996). Interestingly, Hong and Hong (1996) found that although Korean American youth feel obligated to make their parents happy by academic success, about half of the students replied they did not feel close to their parents. This finding suggests a lack of communication between parents and children within the Korean American family (Hong & Hong, 1996).

Hard working parents constitute a third hardship for Korean American children. Most Korean American parents work very hard to make a better living for themselves and for their children (Chu, 1993; Hong & Hong, 1996; Min, 1991 & 1995; Ryu & Vann, 1992). They have little time to play with their children or supervise them at home (Min, 1995). Korean American children lack adults who can help them grow emotionally, intellectually, and socially (Ryu & Vann, 1992). It is very easy for Korean children to ignore school work, go out to meets friends, and get caught up in delinquent activities when no one supervises them at home after school (Min, 1995) In fact, 64 percentage of Korean American junior/high school students in New York responded that there was no parents when they got home after school (Min, 1991). 46 percentage of Korean American students responds that there was no person when they got home after school. This suggested that how easy to fall into delinquent activities in high risky areas such as New York (Min, 1991).

Filial Therapy

Historical development of filial therapy. Utilizing parents as therapeutic agents in their children's lives can be traced to the early part of the 20th century (Landreth, 1991). In 1909 Sigmund Freud (1959) consulted the father of a five year old phobic boy in the famous case of Little Hans. Freud instructed the father in how to respond during play sessions and later interpreted the child's play in sessions with the father. In 1949 Dorothy Baruch (1949) advocated play sessions at home as a way of developing positive parent-child relationships. Natalie Fuchs (1957) reported a positive example of home play sessions with her child based on play therapy procedures suggested in Axline's (1947) writings. With the counsel of her father, Carl Rogers, Fuchs helped her daughter to overcome a toilet-training problem.

As early as 1959, Moustakas (1959) advocated play therapy at home as an essential way to enhance the relationship between a parent and child. He proposed that the child in home play sessions discovers oneself as a valued person as the child allows oneself to express tensions and repressed feelings. Landreth (1991) differentiated between these early experiences of parent-child play sessions at home and filial therapy in that the parents were not regularly trained and supervised by filial therapists, and did not share their experiences with others in a support format.

In the early 1960s, filial therapy was developed in response to the demand for mental health services and the recognition of the great potential of parents as therapeutic agents for change in their children's behaviors (Guerney, 1976). Filial therapy was conceptualized in 1962 by Bernard Guerney and was structured as a treatment for emotionally disturbed children ages three through ten (Guerney, 1964). In filial therapy

parents are trained as therapeutic agents to provide child-centered play therapy skills to their own children. This treatment utilizes naturally and already existing bonds between parents and their children, thus, the term filial therapy (Guerney, Guerney, & Andronice, 1966). Filial therapy was initially designed by Guerney (1976) as a six to twelve months treatment for emotionally disturbed children. Landreth (1991) expanded this original focus of filial therapy to include most children, not just the emotionally disturbed.

Rationale for filial therapy. Filial therapy is modeled after the principles of Person-Centered theory or Child-Centered Play Therapy. It is based upon the central belief of the individual's or child's capacity for growth and self direction in a relationship based on the therapist's or parent's genuineness, warm caring and acceptance, and sensitive understanding which facilitate the release of the child's inner resources (Axline, 1947; Dorfman, 1951; Furman, 1957; B. Guerney, 1967; Katz, 1965; Landreth, 1991).

The underlying rationale of filial therapy is based on the hypothesis that parents can be more effective than a professional therapist if they learn to assume the role of therapists. This is because the parents have an already existing powerful relationship with their own children (Guerney, 1983; Landreth, 1991). Thus, filial therapy focuses on training parents to assist in their children's optimal development by strengthening the relationship between parents and their children (Guerney, 1983).

Unlike traditional therapy where parents may feel guilty and helpless about their children's problems, in filial therapy parents become active allies or essential partners in their child's therapy (Landreth, 1991). Instead of being passive observers, co-clients, or even antagonists, the parents are motivated to help their children's improvement with a specific and new plan (Guerney, B. 1964; Guerney, L., 1983).

Guerney (1983) described two important factors of filial therapy that promote positive and active changes in parents' attitudes and behaviors: (a) being able to help their own child and themselves via training processes that teach them new appropriate ways to behave has enormous motivational power for parents; and (b) through receiving the empathy and support of the therapist, the parents recognize that they are valued and supported. As a result of experiencing the therapist's respect and concern, parents develop insight and growth in both affective and cognitive aspects as well as in the parent-child relationship.

In filial therapy, the therapeutic play relationship is developed between a parent and child rather than between a therapist and child. Thus, the special bond between the parent and child is enhanced. It empowers parents to be actively involved as therapeutic agents for their children. Moreover, their children observe their parents as confident parents, and consequently the children feel more secure and empowered themselves (Guerney, 1976; Landreth, 1991).

Goals of filial therapy. According to Guerney (1976), the goals of filial therapy are to facilitate the emotional and interpersonal development of children and convey to parents knowledge and interpersonal skills in dealing with children that will assist them in creating a positive growth atmosphere in their families. The objective is also to make the knowledge and skill a part of the parents' permanent behavioral repertoire to continue therapeutic gains and growth and to help parents to identify and act appropriately based on their own needs in relation to their children.

Children also receive benefits from play sessions with their parents (Guerney, 1964). The play sessions help children alter their perceptions or misperceptions of their

parent's feelings, attitudes, or behaviors toward them. In these play sessions, children feel free to express thoughts, needs, and feelings to their parents. Thus, they have an opportunity to resolve anxiety-producing internalized conflicts. Filial therapy also helps children become more self-respectful, self-worthy, and self-confident.

Process of filial therapy. Filial therapy is structured to enhance the relationship between parents and their children (Landreth, 1991). Through didactic instruction, viewing of video tapes, and role playing, parents' sensitivity to their children is facilitated, and they learn how to create a nonjudgmental, understanding, and accepting environment in which the children feel safe to explore undiscovered aspects of their individuality (Landreth, 1991). The relationship between parents and their children is enhanced by consistent special play times because the parents play with their child in a consistently empathic manner (Landreth, 1991).

In filial therapy, typically six to eight parents and a therapist are involved in a discussion with lively interaction among parents (Landreth, 1991). At each training session, homework assignments and handouts are given to help maintain involvement between sessions. Parents learn and practice how to recognize and respond to feelings, to employ reflective communication, to engage in appropriate limit setting, to select and prepare a time and place for the play times, and to conduct the sessions. Parents are encouraged to ask questions and take notes. They also receive supervision and feedback about their play sessions in training sessions (Landreth, 1991).

Filial therapy employs didactic and dynamic elements of training which provide an opportunity for parents to learn the principles and skills child-centered play therapy through brief lectures, demonstrations, modeling, and role-playing (Guerney, 1976). This

approach seems to reduce resistance to change and serves as a strong motivational force (Andronico, Fidler, Guerney, & Guerney, 1969). Parents are encouraged to share their feelings about themselves and their children (Landreth, 1991). The expression of these feelings and exploration of their underlying dynamics in the group setting helps parents to prevent conflicts from building up and being acted out at home (Andronico, Fidler, Guerney, & Guerney, 1969).

The attitude of the filial therapist is considered to be a very important dimension in the filial therapy process. Various authors have suggested that the filial therapist should be understanding of parents' difficulties, needs, and emotions, respect their viewpoints, and see the parents as allies in improving the well-being of their children. The necessary conditions of effective filial therapy are cooperativeness, high motivation, and good rapport between the therapist and parents. Therapists teach, supervise, and empower parents to conduct child-centered play sessions with their children (B. Guerney, L. Guerney, & Stover, 1972; VanFleet, 1994). The filial therapist acts as an instructor, skills trainer, supervisor, and consultant to the parents. The therapist also serves as a counselor or psychotherapist for the parents. However, filial therapy is not a parents' backdoor to therapy for parenting or intra-psycho issues (Guerney, 1983).

VanFleet (1994) described essential characteristics for filial therapists. First, they must recognize play as the primary means by which children communicate and through which children can be understood. Their philosophy is that parents have the ability to learn the necessary skills to conduct child-centered play sessions with their own children. Finally, filial therapists must have a preference for educational models of evaluation and treatment rather than biological models.

Filial therapists need to be skilled in group therapy and play therapy since the filial therapy model was originally developed for groups of parents (Landreth, 1991). The therapist is to maintain a sensitive balance between teaching specific skills in filial therapy and exploring emotional experiences. To determine when to shift from teaching moments to exploring moments, the professional should employ clinical judgment (Andronico, Fidler, Guerney, & Guerney, 1969).

Filial therapists supervise parent-child weekly special play sessions either through live demonstrations by the parents or by videotapes that parents make of their play sessions in the home. Parents learn new skills to enhance their relationship with their children through these supervision sessions (Landreth, 1991).

Research on filial therapy. Over thirty years of clinical research has shown the effectiveness of the filial therapy model. Filial therapy is a highly effective program not only as a therapeutic intervention for children with a variety of social and emotional difficulties, but also as a preventative intervention to strengthen parent-child relationships in families where no significant problems exist (VanFleet, 1998).

Stover and B. Guerney (1967) investigated the feasibility of training mothers in filial therapy techniques and found a significant increase in the use of reflective statements by the mothers and a decrease in directive-type statements, as measured by direct observation. Mothers' changes were related to decreased aggressive behavior of their children even during the initial phase. According to the parents' self-reports, the children in the experimental group were exhibiting significantly fewer problematic behaviors at the end of the treatment. There was also a positive influence on the parent-

child relationship and on the child's general emotional adjustment according to the parents' self-reports.

Using the filial therapy model set forth by Guerney (1964), Stollak (1969) trained college students to conduct special play times with children. Twenty volunteer college students received ten weeks of training and then conducted play times with referred children through an on campus clinic. No control group was used, and only children with severe mental retardation, severe emotional disturbance, or brain damage were excluded from the study. Stollak found that the undergraduates made significant improvements in reflection of content and clarification of feelings as a result of the filial training. Stollak reported that the college students demonstrated a competence level in conducting play sessions equal to and greater than many graduate students who received similar training and suggested that this group represented an untapped resource in using children-centered play therapy to treat children.

A later study by B. Guerney and Stover (1971) of a group of 51 mothers and their children substantiated their earlier findings (Stover & B. Guerney, 1967), that mothers could learn to reflect feelings, allow children self-direction, and demonstrate involvement in the emotional behaviors and expressions of their children. Measures completed by clinicians and parents indicated significant improvement on psychosocial adjustment and on symptomatology of the children. No children remained the same or became worse. In order to measure the long term effect of filial therapy training, a follow-up study was conducted by L. Guerney in 1975. Participants gave an overall positive evaluation of the filial therapy training. The responses to the questionnaire indicated that: (a) only one of the 42 children who had participated in the play sessions required further treatment; (b)

32 of the 42 respondents claimed the children to have continuing improvement; and (c) 64 percent of the parents asserted that the children's continuing improvement was related to their improved ability to relate to the children. This study demonstrates that filial therapy is effective with parents and children, and that the results of the training may endure as long as three years later.

Oxman (1971) examined the effectiveness of filial therapy with fifty-one mothers, whose children had been diagnosed as emotionally maladjusted. After 12-months of filial therapy training, the parents reported a significantly greater improvement in the behavior of their children.

Boll (1972) explored the impact of filial therapy training with parents of mentally retarded children by comparing a group of parents trained in traditional filial therapy, a group trained in filial therapy and given additional instruction on specific reinforcement and extinction techniques, and a control group. Both groups trained in filial therapy reported improvement in their children's socially adaptive behavior with the most change occurring in the traditionally trained group. Boll suggested that the difference was due to group dynamics in the traditional group as compared to the other treatment group.

The effectiveness of filial therapy as a treatment method for emotionally disturbed children was demonstrated in a study by B. Guerney (1976). He found that the children who received filial therapy showed significant improvement in social adjustment and reduction in conflicts with parents, teachers, and peers. There was also a significant decrease in the mothers' dissatisfaction with their children and in the number of children's symptoms. The results of filial therapy were equally effective across the range

of the sample regardless of socio-economic background, degree of kind of maladjustment, maternal attitude, or personality variables.

Ginsberg (1976) examined the usefulness of filial therapy in a community mental health agency. He found that the model was beneficial to a variety of problems and contexts within such a setting, and that filial therapy was effective with foster parents, single-parent families, two parent families, and all socioeconomic groups, as an intensive and short-term treatment. Ginsberg concluded that filial therapy could be modified to the nature of the problem, as well as the demands of both the clinic and the family, and could be incorporated with other treatment approaches. In a later study, L. Guerney and Glavin (1981) supported these findings that foster parents were more accepting of their foster children after filial therapy training.

Hornsby and Appelbaum (1978) examined 60 cases of individuals who received filial therapy in a clinic setting. They reported that filial therapy was effective with case examples of a borderline psychotic child, a child in active conflict with a parent, and a handicapped child. Improvement in parent-child relationships and the children's problem behaviors were also evidenced. Parents commented that they liked this approach because they were involved in the psychotherapeutic process.

Sywulak (1979) investigated parental acceptance and child adjustment in order to assess the efficacy of filial therapy. Thirteen mother-father pairs and six single mothers were involved in the experimental group. All participants served as their own controls for a four-month waiting period. The assessment of parental acceptance and child adjustment was measured at four different points in time; (a) at intake, prior to the four-month control period; (b) immediately prior to the onset of treatment; (c) after two months of

treatment; and (d) after four months of treatment. Significant improvement in parental acceptance and significant changes in child adjustment were achieved at the two-month mark. Those changes were maintained throughout the four months of treatment. Interestingly, changes in withdrawn children occurred more quickly than changes in aggressive children. Mothers appeared to perceive an increase in child adjustment earlier than did fathers. Sensue (1981) conducted a follow up of the Sywulak study. Results showed significant improvement in parental acceptance and an increased capacity and willingness to continue using the filial skills with their children 6 months after treatment, with no significant losses 2 to 3 years later.

In a comparison study, Wall (1979) examined three variations of play therapy conducted by: (a) graduate therapist trainees; (b) non-trained parents; and (c) parents directed and observed by therapist trainees. Parents who were guided by the therapist trainees improved their skills in empathic communication with their children. The findings reflected that the children's expression of negative feelings and their increased perception of negative attitudes in their families led to improved adjustment. This may suggest that the acceptance of negative feelings by a parent has a more powerful impact on a child than does acceptance by a therapist. Also, parents who conducted play therapy significantly improved their ability to communicate empathically with their children after treatment.

In a similar investigation, Lebovitz (1983) compared the effectiveness of a filial therapy group, a group conducting supervised play sessions, and a group receiving no treatment. Parent's filial skills were assessed, and parents, teachers, and independent observers assessed change in children's behavior. Assessments of children in both the

filial group and the supervised play session's group revealed fewer behavioral problems as compared to the control group. Parents in the filial therapy group experienced several significant increases over the supervised play session's group: greater decrease in children's problem behavior; parents communicated more acceptance of feelings, allowed children more self direction, and exhibited more involvement with their children; and the children demonstrated greater decrease in dependence on their parents.

Glass (1986) conducted a study to determine the effect of the Landreth (1991) 10-week filial therapy model on parental acceptance, self-esteem, parent-child relationship, and family environment. Her study involved fifteen parents in filial therapy and twelve parents in the control group. Glass reported a significant increase in the parents' feelings of unconditional love for their children and a significant decrease in the parents' perceptions of expressed conflict in their family as compared to the control group.

In a comparison of parent and paraprofessional filial groups, Payton (1980) demonstrated that parents trained in filial therapy are more effective in impacting their children's personality adjustment than paraprofessionals. Parents in the filial therapy training group also showed significant improvement in child-rearing attitudes.

Children who received play therapy sessions with their parents in addition to sessions with a therapist were studied by Kezur (1980). Communication patterns between mother and child and their impact on the relationship were examined. The study revealed that: (a) effective communication skills, based on therapeutic principles, were developed by the mothers; (b) the children expressing anger towards the mother in the therapist play sessions became more open with their mothers in the parent play sessions; (c) mothers developed more insights into their communication; (d) mothers who developed personal

insights changed with their children in a positive direction; (e) mothers who learned to honor their own needs were better able to meet the needs of their children; (f) new communication skills were developed by mothers who accepted joint responsibility for the problems with their children; (g) the greater gain in new communication skills were made by those mothers who opened themselves to a relationship with the researcher; (h) positive changes developed in the mother-child relationship as both gained in self-esteem; (i) mothers who were open to viewing and commenting on themselves in videotape replays gained more from the feedback; (j) as mothers and children became more involved in the joint sessions, there was an increase in closeness and effective communication; and (k) in the pairs of mothers and children where the most change occurred, the mothers tended to report improvement in other relationships.

Packer (1990) utilized a case study approach and identified significant change in family dynamics following filial therapy training. The dynamics of the mother-father-child triad shifted after filial therapy training, wherein the father was more readily accepted as an authority figure in the presence of the mother than had been the case prior to filial therapy training. As a result of 10 weeks of filial therapy training, the parents gained a new perception of themselves as possessing skills that could affect positive change in their children, and the child demonstrated a growing ability to control escalation of rising emotions in both the home and the child care setting with a marked reduction of temper tantrums.

Utilizing ethnographic methodology, Lahti (1993) examined the effects of the Landreth (1991) 10-week filial therapy model on the child, parent, and parent-child relationship. Parents reported that their levels of stress lessened as a result of the practice

parent-child play sessions and their objectivity for learning was enhanced through the viewing of parent-child videotaped sessions in class in which the facilitator and parents exchanged feedback. Participating parents reported increased self-confidence, less need to enforce parental control, and increased awareness of their own personal needs and the needs of their children. In the area of relationships, parents reported increased closeness and enhanced communication in both the parent-child relationship and the marital relationship, the development of more realistic expectations for their child, and a reduction of friction between parents and children. Crediting filial therapy for the changes within the family, parents perceived their children as happier, taking more responsibility for their actions, being less withdrawn, demonstrating fewer aggressive behaviors, and exhibiting an overall increase and enhancement in communication.

The Landreth (1991) 10-week filial therapy model has been used as an intervention with families of chronically ill children. Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) concluded that filial therapy can have a positive impact on children with chronic illness and their families. Although the children's anxiety level did not change, parents were more accurate in their judgment of their children's self report of anxiety. There was also an increase in parental acceptance of their children, and they reported significant unspecified but positive changes in their relationships with their children.

In a similar study, Tew (1997) also examined the efficacy of the Landreth (1991) 10-week filial therapy model with parents of chronically ill children. Thirteen parents were involved in filial therapy, and fifteen parents were involved in the control group. As a result of the filial therapy, the parents reported a significant decrease in stress related to

parenting, a significant increase in accepting attitudes toward their children, and a significant reduction in their children's behavior problems as well as in their anxiety and depression. Furthermore, parents in filial therapy reported feeling more in control of their children by listening and responding, and expressed that their role as a parent was more manageable and more fun.

In a study of the effectiveness of filial therapy with single parents, Bratton and Landreth (1995) examined the use of the Landreth (1991) 10-week filial therapy model with single parents in an experimental-control group design. They reported that single mothers developed healthier parenting skills and the weekly training group sessions provided needed emotional support. Compared to control group parents, the filial group parents: (a) increased their level of empathy in their interactions with their children; (b) increased their attitude of acceptance toward their children; (c) reduced their level of stress related to parenting; and (d) experienced fewer problems with their children's behavior.

Bavin-Hoffman, Jennings, and Landreth (1996) conducted a follow up study of twenty married couples who had completed the Landreth (1991) 10-week filial therapy model. A phenomenological approach was used to examine couples' perceptions of how their family changed after the filial therapy experience and how their marital relationship changed during and after the experience. Couples completed filial therapy training between 1991 and 1994. Audiotaped interviews were transcribed and analyzed. Based on the findings, the following observations of the changes after filial therapy were reported: (a) parent-child interpersonal communications improved; (b) interpersonal communication improved between spouses; (c) children's aggression decreased; (d)

children's self control of their own behavior increased; and (e) family relationships improved. Other findings suggested that a side effect of this training was increased couple unity and value. This study points to the fact that when parents are more unified in parenting goals and strategies there is greater marital harmony and reduced parenting anxiety.

Landreth and Lobaugh (1998) investigated the effectiveness of the Landreth (1991) 10-week filial therapy model with incarcerated fathers. The fathers in filial therapy significantly increased their acceptance of their children and decreased their stress. They reported significantly fewer problems in the posttest checklist. Moreover, there was a significant increase in their children's self-concepts as a result of filial therapy. Similarly, Harris and Landreth (1995) studied the effectiveness of filial therapy with incarcerated mothers. They reported this method was an appropriate intervention in working with incarcerated mothers in a five-week, bi-weekly training model. The experimental group mother showed significant changes in maternal empathic interactions with their children, attitude of acceptance towards their children, and a reduction in number of problems with their children's behaviors in comparison to the control group.

Costas and Landreth (1999) conducted research on the effectiveness of the Landreth (1991) 10-week filial therapy model as a method of intervention for non-offending parents and their children who had experienced sexual abuse. The experimental group parents made several changes within the statistically significant range, including increased parental acceptance and unconditional love, reduction of stress as related to parenting, increased empathic interactions, and communication of acceptance of children's feelings and behaviors during observed play sessions. Parents in the

filial therapy group also rated their children's behaviors within a normal range at the completion of training. Costas and Landreth identified this change as important because parents' assessment of their children with a more developmentally accurate perspective was interpreted as definite progress in light of the heightened anxiety typical of parents whose child has been sexually abused. Though control group parents maintained their attempts to control their children's behaviors, the parents in the training group made significant gains in following the child's lead and allowing the child more self direction. Costas and Landreth identified the shift in parental control and imposed direction on the child as significant because non-offending parents are often so over protective they inhibit the natural developmental flow in the child who has been sexually abused.

As an adaptation of the Landreth (1991) 10-week filial therapy training model, Child-Teacher Relationship (CTR) training was developed by Brown (2000). CTR is an intervention for teacher trainees to increase the teacher trainees' awareness and use of relationship skills utilizing basic child-centered play therapy principles. Brown examined the effectiveness of CTR training with undergraduate teacher trainees. Significant increases were reported in the teacher trainees' empathy towards children, allowing the child self-direction, communication of acceptance, and involvement as compared to the control group. Teacher trainees in the experimental group also showed significant increases on play therapy attitudes, knowledge, and skills.

Smith (2000) studied the effectiveness of the intensive filial therapy model with parent victims of domestic violence. Smith collapsed the Landreth (1991) 10-week filial therapy training model into 12 daily sessions of one and half hours rather than weekly sessions. The mothers in filial therapy training showed a significant increase in

communication of empathy to their children. Children of mothers who received filial therapy training reported significant increases in self-concept, and demonstrated a reduction of overall behavior problems as compared to a control group. Smith also comparatively analyzed the effectiveness of intensive filial therapy, intensive individual play therapy (Kot, 1995), and intensive sibling group play therapy (Tyndall-Lind, 1999) with child witnesses of domestic violence. Intensive filial therapy, intensive individual play therapy and intensive sibling group play therapy were shown to produce comparable results with one exception in which intensive individual play therapy was more effective at improving children's self-concepts.

The Landreth (1991) 10-week filial therapy model has been demonstrated to be an effective model with parents in different ethnic groups. Chau and Landreth (1997) conducted filial therapy with Chinese parents in the United States and reported significant increases in parent's empathic interactions with their children, and in improving their attitude of acceptance toward their children as compared to a control group. There was also a significant reduction in parental stress. Yuen (1997) found similar results of filial therapy training with immigrant Chinese parents in Canada. Moreover, Yuen found that the Chinese parents' perceived number of problem behaviors in their children was reduced, and that the self-concept of their children was enhanced as a result of filial therapy.

Jang (2000) examined the effectiveness of filial therapy with Korean parents in Korea. As a result of filial therapy, Korean parents' empathic interactions with their children increased significantly. Their parenting stress and their perceived number of problem behaviors in their children were significantly reduced.

Filial therapy was examined for its effectiveness with Native Americans (Glover & Landreth, 2000). Glover and Landreth utilized filial therapy with parents on the Flathead Reservation in Montana and found a significant increase in parent's level of empathy as compared to a control group. Children in the experimental group significantly increased their level of desirable play behaviors with their parents compared to the control group. In the areas of parental acceptance, parental stress, and children's self-concepts positive trends were noted on all measures.

Generally, these studies (Chau & Landreth, 1997; Glover & Landreth, 2000; Jang, 2000; Yuen, 1997) show that filial therapy is an effective intervention for culturally different parents for: (a) increasing parents' empathic behaviors; (b) increasing parent's acceptance level toward their children; (c) reducing parents' stress level; (d) reducing parents' perceived number of problem behaviors in their children; and (e) enhancing the self-concept of their children.

CHAPTER II

METHODS AND PROCEDURES

The purpose of this study is to determine the effectiveness of filial therapy in: (a) increasing Korean immigrant parents' empathic behavior with their children; (b) increasing Korean immigrant parents' attitude of acceptance toward their children; and (c) reducing Korean immigrant parents' stress related to parenting. This chapter will address definition of terms, hypotheses, instruments, selection of subjects, collection of data, and statistical analysis.

Definitions of Terms

Allowing the child self-direction is the parent's willingness to follow the child's lead rather than trying to control the child's behavior. For the purpose of this study, allowing the child self-direction was operationally defined as the parents' scores on this subscale of the Measurement of Empathy in Adult-Child Interaction (Stover et al, 1971).

Appreciation for the child's unique make-up is the parents' attitude of appreciating and valuing the child's uniqueness. For the purpose of this study, appreciation for the child's unique make-up was operationally defined as the parents' score on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Child-centered Play Therapy is defined in this study as:

“A dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings,

thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (Landreth, 1991, p. 14).

Communication of acceptance is the parent's verbal expression of acceptance of the child. For the purpose of this study, communication of acceptance was operationally defined as the parents' scores on this subscale of the Measurement of Empathy in Adult-Child Interaction (Stover et al., 1971).

Empathy is the parents' sensitivity to their children's current feeling and parents' ability to verbally communicate this understanding to the child. For the purpose of this study, empathy was operationally defined as the parents' total scores on the Measurement of Empathy in Adult-Child Interaction (Stover et al., 1971).

Filial Therapy is defined in this study as "a unique approach used by professionals trained in Play Therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play session, and supervision. Parents are taught basic child-centered play therapy skills including responsive listening, recognizing children's emotional needs, therapeutic limit setting, building children's self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment which enhances the parent-child relationship, thus facilitating person growth and change for child and parent" (G. Landreth, personal communication, January 24, 2001).

Immigrant Korean parent is defined in this study as a Korean parent with a child between the ages of 2 years and 10 years, who migrated to the United States.

Involvement is the parent's attention to and participation in the child's play session activities. For the purpose of this study, involvement was operationally defined as the parents' scores on this subscale of the Measurement of Empathy in Adult-Child Interaction (Stover et al., 1971).

Parental Acceptance is the ability of the parent to recognize and approve of the child regardless of appearance, abilities, or behavior. For the purpose of this study, parental acceptance was operationally defined as the parent's total score on the Porter Parental Acceptance Scale (Porter, 1954).

Parental Stress is the degree of stress perceived by the parent in the parent-child system. For the purpose of this study, parental stress was operationally defined as the parents' scores on the Parenting Stress Index (Abidin, 1983).

Recognition of the child's need for autonomy and independence is the parent's understanding of their children's need to differentiate and separate from their parents in order to achieve their own identity. For the purpose of this study, recognition of child's need for autonomy and independence was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Respect for the child's feelings and right to express them is the parent's willingness to allow the child to express feelings and to show acceptance for the child. For the purpose of this study, respect for the child's feelings and right to express them was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Unconditional love is the love a parent shows toward a child without placing conditions or minimum standards on the child's behavior in order to receive that love.

For the purpose of this study, unconditional love was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Hypotheses

To carry out the purpose of this study, the following hypotheses were formulated:

1. The experimental parent group will attain a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will parents in the control group.
 - a) The experimental group parents will attain a significant lower mean score on the Communication of Acceptance subscale of the MEACI posttest than will the control group parents.
 - b) The experimental group parents will attain a significantly lower mean score on the Child Self-Direction subscale of the MEACI posttest than will the control group parents.
 - c) The experimental group parents will attain a significantly lower mean score on the Involvement subscale of the MEACI posttest than will the control group parents.
2. The experimental group parents will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) posttest than will the control group parents.
 - a) The experimental group parents will attain a significantly higher mean score on the Respect for the Child's Feelings and Right to Express Them subscale of the PPAS posttest than will the control group parents.

- b) The experimental group parents will attain a significantly higher mean score on the Appreciation of the Child's Unique Makeup subscale of the PPAS posttest than will the control group parents.
 - c) The experimental group parents will attain a significantly higher mean score on the Recognition of the Child's Need for Autonomy and Independence subscale of the PPAS posttest than will the control group parents.
 - d) The experimental group parents will attain a significantly higher mean score on the Loves Child Unconditionally subscale of the PPAS posttest than will the control group parents.
3. The experimental group parents will attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will the control group parents.
- a) The experimental group parents will attain a significantly lower mean score on the Parent domain of the PSI posttest than will the control group parents.
 - b) The experimental group parents will attain a significantly lower mean score on the Child domain of the PSI posttest than will the control group parents.

Limitations

The results of this study may be limited due to the specific population of immigrant Korean Parents selected in the Dallas metroplex area and the small number of subjects (N=32) included in the study. Because the immigrant Korean population in the study is limited to the Dallas metroplex area, the results of this study may not be generalizable to all immigrant Korean populations in the United States.

Due to the nature of the population and the purpose of this study, random selection was not possible. Future research in this area would benefit from random

assignment to clarify any underlying issues related to motivation of volunteer participants and the possible Hawthorne effect resulting from such a group.

Instruments

Measurement of Empathy in Adult-Child Interaction

The Measurement of Empathy in Adult-Child Interaction (MEACI) was developed by Stover, B. Guerney, and O'Connell (1971) to operationally define empathy as related to parent-child interactions. It measures three parental behaviors identified as major aspects of empathy in adult-child interaction: (a) communication of acceptance; (b) allowing the child self-direction; and (c) involvement. The scale also provides a total empathy score. Lower scores indicate higher levels of positive behavior in the total score and in each of the subscales.

The "Communication of Acceptance" subscale measures the parent's verbal expression of acceptance of the child's feelings and behavior in spontaneous play with the child. The dimension of acceptance is viewed as a necessary condition for optimal development of the child's self-worth and the major element in the communication of empathy (Stover et al., 1971). Stover et al. believed that the communication of acceptance does not generally occur in spontaneous parent-child interactions. They hypothesized that the verbal expression of acceptance was a major element in explaining exceptionally positive or healthy adult-child relationships.

The "Allowing the Child Self-Direction" subscale measures the parent's behavioral willingness to allow the child self-direction in behavior rather than attempting to control the child's behavior.

The “Involvement” subscale measures the parent’s attention to and participation in the child’s activity. Involvement may be sympathetic or nonsympathetic, appropriately supportive or highly directive. Stover et al. (1971) found that parents who exhibited high levels of communication of acceptance and allowing the child self-direction also demonstrated high levels of involvement.

A five-point bipolar scale is used to rate the three dimensions of parental behavior every three minutes of the video-taped play sessions for six consecutive coding intervals. The scale ranges from a high rating of one to a low rating of five. Each point on the scale is followed by typical responses obtained from codings of the direct observations of parent-child interactions. An Empathy score may be obtained by totaling the three totals of the subscales. The lower the score, the more empathic the behavior. The highest level of empathy is evident when the parent (a) comments frequently on the child’s expression of feeling or behavior in a genuinely accepting manner; (b) demonstrates clearly that the child is fully permitted to engage in his or her present activity; and (c) attends fully to the child’s behavior. The lowest level of empathic communication is evident when the parent is either (a) verbally rejecting the feelings or behavior of the child; (b) shutting off from the child who has to repeat or prompt to get a response from the parent; (c) demanding, and redirecting the child’s activity (Stover et al., 1971).

Reliability coefficients were established for each of the three subscales. After four training sessions of collaborative rating on half hour play sessions and discussion, six pairs of coders separately rated seven to ten mother-child plays sessions of 20 minutes to one half hour each. The average reliability correlation coefficients for the three subscales were .92, .89, and .89 (Stover et al., 1971).

The instrument demonstrated concurrent validity by correlating .85 with a previously developed measure of empathy, and offered measures of three other variables which are relatively independent of one another. Construct validity for the total empathy score and each subscale was demonstrated with a group of 51 mothers who participated in Filial Therapy training. Significant differences were found not only between the pretraining and the posttraining session, but even between the first and third of the training sessions. It suggests that the scales are extremely sensitive measures of the behaviors in question (Stover et al., 1971).

Porter Parental Acceptance Scale (PPAS)

The Porter Parental Acceptance Scale (PPAS) was developed by Porter (1954). It is a 40-item self-report inventory type questionnaire requiring approximately 20-30 minutes to complete. The acceptance scale is designed to measure parental acceptance of children as revealed in the behavior and feelings parents express toward, with, or about their child. The PPAS involves four dimensions of acceptance: (a) respect for the child's feelings and right to express them; (b) appreciation of the child's uniqueness; (c) recognition of the child's need for independence and autonomy; and (d) unconditional love. This PPAS was used for this study because these four variables are closely associated with the training objectives of filial therapy and this instrument has been used in other studies on filial therapy training. The PPAS is easy to administer and takes approximately 20 minutes to complete.

Each question has five responses ranging from low to high acceptance. There are two dimensions of acceptance: (a) how the parent feels in a specific situation, and (b)

what the parent will do in a specific situation. It is scored to yield four subscale scores and one total scale score.

Porter (1954) reported a split-half reliability correlation of .766 raised by the Spearman Brown Prophecy formula to .865. Another research project reported a split-half reliability coefficient of .80 by utilizing the Spearman Brown Prophecy formula. Both coefficients are significant beyond the .01 level.

Porter (1954) investigated the validity of the instrument by using five expert judges to rank the responses on a continuum of one representing low acceptance to five representing high acceptance. On all items there was agreement among at least three out of the five judges. The greatest degree of disagreement was by a distance of only two scale points which occurred in less than 20 percent of the responses suggesting that the operational definition of parental acceptance that Porter (1954) created is valid as measured by this scale.

Burchinal, Hawkes, and Garner (1957) utilized an item analysis to study the internal consistency of the PPAS. By analyzing both fathers' and mothers' responses, the researchers found that 39 of the 40 items discriminated between high and low scorers. The value of 3.46 needed for a probability level of .001 was exceeded by 35 items in the mothers' responses and 33 items in the fathers' responses. Thus, the findings from this study indicate that the PPAS is internally consistent at the .001 level of probability. This instrument was thus deemed to be internally consistent.

Parenting Stress Index (PSI)

The Parenting Stress Index (PSI) was developed by Abidin (1983). This self-report inventory is to measure the level of stress in the parent-child system. It is a 101 item self-report index and is separated into two domains, the child domain and the parent domain. The child domain indicates how a parent perceives the child in relation to levels of Adaptability, Acceptability, Demandingness, Mood, Distractibility, and Reinforcing Behavior for parents. The parent domain measures the parent's perceived level of Depression, Attachment, Role Restrictions, Competence, Social Isolation, Spouse Relations, and Health. The PSI is easy to administer, and can be completed in 20 minutes. There are five possible responses that range on a continuum from strongly agree to strongly disagree in each item.

The reliability coefficients were based on responses of a sample of 2633 subjects. The reliability coefficients for the two domains and Total Stress Score are: Child Domain .90; Parent Domain .93; and Total Stress Score .95 (Hauenstein, Scarr, & Abidin, 1986). All items in the instruments are directly related to one of the sub-domains. Content validity is very high.

Zakreski (1983) used the test-retest method to determine a coefficient of reliability. This study produced coefficients of reliability. This study produced coefficients of .77 for the child domain, .69 for the parent domain, and .88 for the total index. Alpha reliability coefficients were calculated on the total score and one each of the domains to determine internal consistency. The coefficient reported for the child domain was .89 and the coefficient for the parent domain was .93 with a total reliability

coefficient of .95. These finding indicate a high degree of internal consistency of the PSI (Hauenstein, Scarr, & Abidin, 1986).

This PSI was selected for use in this study because (a) the value conflict of immigrant Korean parents is associated with high level of parenting stress, (b) the subscales are closely related to parents' ability to accept their child; and (c) this instrument has been used in other studies of Filial Therapy training.

Selection of Subjects

The population studied consisted of immigrant Korean parents in the Dallas area. Announcements stating the beginning of "child-parent relationship enhancement classes" were made and fliers were posted at various Korean churches in the Dallas area. The classes were offered free of charge. Thirty two parents were randomly selected to participate in the study. Parents meeting the following criteria were selected to participate in the study: (a) must be immigrant Korean; (b) must be able to speak and read Korean, or English; (c) must have a child between the ages 2 to 10 years who has not received therapy and is not currently in therapy; (d) must not have taken a parenting class in the last two years; (e) must be able to attend the ten weeks of filial therapy at the scheduled times; (f) must be able to attend a pretraining session to complete pretest instruments and be videotaped playing with their child; (g) must be able to attend a posttraining session to complete posttest instruments and be videotaped playing with their child; (h) must agree to participate in weekly 30-minute home play sessions with their child; and (i) must be willing to sign the consent form to participate.

The investigator met with each parent who satisfied the specified criteria to explain the purpose and the requirements of the filial therapy training, to provide

information about how confidentiality would be maintained, and to answer any questions from the parents had before they signed the consent form (Appendix A). Each parent was asked to choose one of their children, between the ages of two and ten, as the “child of focus” for the ten-week training period. The investigator informed the parents that they would be arbitrarily scheduled to participate in either the first series (experimental group) or second series (control group) of filial therapy training classes.

All of the thirty-six parents who volunteered for the filial therapy training met the selection criteria. Eighteen of these parents were randomly selected for the experimental group and divided into three groups with ten, six, or two parents in each group. The other eighteen parents were placed in the control group. Three filial groups were offered in two Korean churches, and at one subject’s house.

All parents who met the criteria specified above ($n=36$) were scheduled to bring their “child of focus” to a pretraining session to complete all pretest requirements. All thirty-six subjects completed the pretraining requirements and were included in the study.

The investigator randomly assigned parents to the experimental group ($n=18$) and the control group ($n=18$). Over the course of the ten week treatment period, one subject from the experimental group and three subjects from the control group dropped out of the investigation because of a family crisis and conflicting schedules. Thus, thirty-two subjects completed the present study, seventeen in the experimental group and fifteen in the control group. The Korean language was used to communicate with all parents.

The experimental group was comprised of seventeen mothers. The control group was comprised of fifteen mothers. The parents in the experimental group ranged in age

from 31 to 45 years of age, with a mean age of 38. The age range for the control group parents was 30 to 45 years of age, with a mean age of 37.

Of the experimental group, one (5.9%) parent had completed junior high school, eight (47%) had completed high school, and eight (47%) had completed college. Of the control group, four (26.7%) had completed high school, seven (46.7%) had completed college, and four (26.7%) had completed a graduate degree.

Of the experimental group, three (17.6%) parents had been living in the United State for 1 to 2 years, one (5.9%) for 2 to 4 years, three (17.6%) for 4 to 6 years, two (11.8%) for 6 to 8 years, two (11.8%) for 8 to 10 years, and six (35%) for more than 10 years. Of the control group, two (13.3%) parents had been living in the United States for 2 to 4 years, one (6.7%) for 4 to 6 years, two (13.3%) for 6 to 8 years, two (13.3%) for 8 to 10 years, and eight (53.3%) for more than 10 years.

Of the experimental group, nine (52.9%) parents were employed full-time, and eight (47.1%) were full-time parents. Of the control group, nine (60%) parents were employed full-time, and six (40%) were full-time parents.

There were nine boys and eight girls in the experimental group. The age range was 2 to 10 years of age, with a mean age of 7.3 years. The experimental group included 1 (5.9%) 2-year old, 1 (5.9%) 3-year old, 1 (5.9%) 4-year old, 2 (11.8%) 5-year olds, 3 (17.6%) 6-year olds, 1 (5.9%) 7-year old, 2 (11.8%) 8-year olds, 3 (17.6%) 9-year olds, and 3 (17.6%) 10-year olds. There were eight boys and seven girls in the control group. The age range was 2 to 10 years of age, with a mean age of 7.3 years. The control group included 2 (13.3%) 2-year olds, 1 (6.7%) 3-year old, 1 (6.7%) 4-year old, 1 (6.7%) 6-year

old, 3 (20%) 7-year olds, 2 (13.3%) 8-year olds, 1 (6.7%) 9-year old, and 4 (26.7%) 10-year olds.

Collection of Data

Pretraining sessions were scheduled during two weeks prior to the first series of filial therapy training classes for the purpose of collecting data. All parents completed the (a) Porter Parental Acceptance Scale and the (b) Parenting Stress Index and then were videotaped playing with their child for 20 minutes in one of the playrooms before and after the training. Both Korean and English versions of the questionnaires were provided for the parents. All parents were asked to choose either version to complete. The investigator and two research assistants supervised the data collection. The investigator was bilingual and used Korean to communicate with the parents in the process. The research assistants were Japanese, and they used English to communicate with children in the process because children were more comfortable with using English than Korean. The investigator was available to answer any questions. As the parents completed the questionnaires, the research assistants directed each parent and child of focus to the playroom for videotaping in nonspecified play with their child for 20 minutes in a room in their church temporarily converted into a playroom with toys and materials recommended by Landreth (1991) for a typical play therapy room. The parent and child were shown the playroom with the explanation, “this is a room where children and parents can play together. You may play with the toys in lots of the ways you would like.” The investigator or research assistants then told the parent and child that she would knock on the door at the end of the 20 minutes to signal that time was up.

One week following the completion of the ten weekly filial therapy training sessions, the posttest battery of instruments was administered to both the experimental and control groups. The posttraining sessions followed the same procedures outlined in the pretraining sessions. The control group parents were scheduled to begin filial therapy training as soon as they completed the posttesting requirements.

All instruments and videotapes were number coded to maintain the confidentiality of the participants. The investigator kept a master list with subjects' names and respective codes in a locked file. The control group parents were scheduled to begin filial therapy training after they completed the posttesting requirements.

Ten-week Training Model (Treatment)

The experimental group parents participated in a 10-week model of filial therapy (Landreth, 1991). Each group met weekly for a two-hour training session for ten consecutive weeks in Korean churches. The groups conducted in Korean. Materials utilized in the training were translated into Korean by the investigator. Parents used Korean, or English to conduct play sessions at home.

The following training session outline is from Landreth (1991):

Training Session One

Parents were asked to introduce self, describe family, and characterize child they would have special play sessions with. Parents are encouraged to work with only one child during training to increase consistency. Goals and objectives of the training were explained. The homework assignment is to identify emotions of anger, happiness, sadness, and surprise in their child of focus and make a reflective response. Responses are to be written down for reporting to the group.

Training Session Two

Parents shared their homework assignments on identifying and reflecting feelings. Empathic responding was elaborated on and the facilitator demonstrated empathic responding with a volunteer followed by viewing of a video tape of the facilitator in a play session with a child. Parents had opportunity to pair off and practice reflective responding. Parents were given a list of toys (Play Doh, crayons, paper, blunt scissors, nursing bottle, rubber knife, dart gun, doll family, toy soldiers, car, play money, rope, transparent tape, Bobo, ring toss, small cardboard box with window and door cut in side doubles as doll house and container for toys). Facilitator demonstrated each toy and explained their purpose in the special sessions. The homework assignment was to put the toy kit together. Parents were asked to select a time and an uninterrupted place in the home suitable for the play sessions. The play sessions may not be interrupted to convey importance to the child and communicate the child is special.

Training Session Three

Parents were asked to report on arrangements for their play sessions. Facilitator taught play therapy skills to parents with role play and a second video taped play session of the facilitator with a child. The facilitator may use a live demonstration with one of the parent's children. The homework assignment was helped the child make a "Play Session—Do Not Disturb" sign to hang on the door and to have the first play session at home. Parents were given a list of play time rules and adhere to them. One parent was asked to bring video taped play session.

Training Session Four

Parents had opportunity to report their first play session at home. Areas of difficulty were discussed with suggestions offered by the facilitator. Facilitator paid attention to the feelings parents experienced with support and encouragement. A video tape of a parent play session was viewed with feedback given from the other parents in the group. Usually this experience produces considerable anxiety, but the facilitator and the rest of the group provided extremely support, and the anxiety decreased.

Training Session Five through Nine

These sessions followed the same general format. Parents briefly reported on their play sessions at home. The facilitator gave suggestions and instruction, facilitated group interaction on common problems, and paid attention to parents' feeling. A parent video tape was viewed and discussed each time. Training and role playing of skills were continued each session. The facilitator identified newly developed parental coping skills in parents to develop their sense of personal power, generalization of skills outside the play sessions was discussed.

Training Session Ten

Parents reported on their play sessions, parent session was viewed. The last hour was spent with parents sharing their evaluation of the experience and how and if they and their child have changed. The facilitator shared notes of parents' original descriptions of their children as point of reference for parents to evaluate progress.

Facilitator

All the filial therapy training groups were facilitated by the investigator of this study. The investigator is a National Certified Counselor, a Developmental Psychologist, a Licensed Professional Counselor-Intern in the state of Texas, and a doctoral student at the University of North Texas with a master's degree in child counseling. She has completed an introduction to play therapy course, an advanced play therapy course, and a filial therapy course. In addition the investigator has received supervision of play therapy experiences in a master's degree practicum, an advanced doctoral practicum, and a doctoral internship. She also has conducted several filial therapy training groups and provided play therapy supervision for master's level students. She speaks Korean and English.

Statistical Analysis

Following the collection of the pretest and posttest data, the three self-reports from the parents were blind-scored by the researcher and double-checked by a research assistant. The pre- and post-training video tapes of parent-child play sessions were rated upon completion of the study to insure that the raters did not know whether they were rating a pre-training or post-training session. A visiting professor on her sabbatical leave from Korea with training in play therapy and filial therapy and a master student with advanced course work and training in play therapy were blindly rated the video tapes. The pre and posttraining video tapes of parent-child play were not rated until completion of the study to insure that the raters did not know whether they were rating a pretraining or posttraining session. The investigator trained the rater in a 2 hour training session to ensure the consistency of the scale. Training included discussions and collaborative rating

sessions following the procedures outlined by Stover et al. (1971). Interrater reliability for the two raters was also checked midpoint of the scoring process and again at the end of the scoring process. A coefficient of reliability, chronbach's alpha, was used to calculate interrater reliability. Table 1 contains the resulting reliability coefficients.

Table 1

Interrater reliability for the Measurement of Empathy in Adult-Child Interactions
(MEACI)

| Variables | Training Session | | |
|-----------------------------|------------------|----------------|--------------------|
| | I Pre-coding | II Midpoint | III Post-coding |
| Communication of acceptance | 0.8636 | 0.7857 | 0.9676 |
| Allowing self-direction | 0.4528 | 0.8496 | 0.9981 |
| Parental involvement | 0.9487 | 0.9266 | 0.5797 |
| Total empathy | 0.7677 | 0.9248 | 0.9952 |

For the purpose of statistical analysis, data from the three filial therapy training groups was pooled to form the treatment group. The resulting data was keyed into the computer and analyzed using SPSS (1993).

An analysis of covariance (ANCOVA) was conducted to test the significance of the difference between the experimental group and the control group on the adjusted posttest means for each hypothesis. In each case the posttest specified in each of the hypotheses was used as the dependent variable and the pretest as the covariant. ANCOVA was used to adjust the group means on the posttest on the basis of the pretest, thus statistically equating the control and experimental groups. Significance of difference

between means was tested at the .05 level. On the basis of the ANCOVA, the hypotheses were either retained or rejected.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis tested in this study. Also included is a discussion of the results, summary, and recommendations for future research.

Results

The results of this study are presented in the order the hypotheses were tested. Analyses of covariance were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

The experimental parent group will attain a significantly higher mean total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the control parent group.

Table 2 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 3 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 2

Mean Total Scores for the Measurement of Empathy in Adult Child Interaction (MEACI)

| | Experimental ($n=17$) | | Control ($n=15$) | |
|-----------|-------------------------|----------|--------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 59.882 | 31.235 | 62.200 | 62.867 |
| <u>SD</u> | 5.808 | 6.665 | 8.055 | 10.042 |

Total cases= 32

Note. A decrease in the mean score indicates an increase in empathic behavior.

Table 3

Analysis of covariance data for the mean total scores on the Measurement of Empathy inAdult Child Interaction (MEACI)

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 7332.997 | 1 | 7332.997 | 110.331 | .000* | 1.000 | .726 |
| Covariates | 195.341 | 1 | 195.341 | 2.939 | .097 | .381 | .019 |
| Error | 1927.451 | 29 | 66.464 | | | | .191 |
| Corrected total | 10095.875 | | | | | | |

* $p < .001$

Table 3 shows the *F* ratio for the main effects was significant to the .001 level, *F* (1, 29)=110.331, $p < .001$, indicating a significant increase in the experimental group parents' empathic interaction with their children during observed play sessions. On the basis of this data, hypothesis 1 was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is large (.726).

Hypothesis 1.a

The experimental parent group will attain a significantly higher mean score on the Communication of Acceptance subscale of the MEACI posttest than will the control parent group.

Table 4 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 5 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 4

Mean scores for the MEACI subscale: Communication of Acceptance

| | Experimental (n=17) | | Control (n=15) | |
|-----------|---------------------|----------|----------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 20.412 | 12.588 | 21.133 | 20.867 |
| <u>SD</u> | 2.647 | 2.852 | 2.356 | 3.314 |

Total cases= 32

Note. A decrease in the mean score indicates an increase in communication of acceptance.

Table 5

Analysis of covariance data for the mean scores on the MEACI subscale: Communication of Acceptance

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 519.363 | 1 | 516.363 | 54.141 | .000* | 1.000 | .622 |
| Covariates | 7.269 | 1 | 7.269 | 7.269 | .390 | .135 | .008 |
| Error | 276.582 | 29 | 9.537 | | | | .333 |
| Corrected total | 829.969 | | | | | | |

* $p < .001$

Table 5 shows the *F* ratio for the main effects was significant to the .001 level, $F(1, 29)=54.141$, $p < .001$, indicating a significant increase in the experimental group parents' verbal expression of acceptance of their children's feelings and behaviors during observed play sessions. On the basis of this data, hypothesis 1.a was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is medium (.622).

Hypothesis 1.b

The experimental parent group will attain a significantly higher mean score on the Allowing the Child Self-Direction subscale of the MEACI posttest than will the control parent group.

Table 6 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 7 presents the analysis of covariance data,

showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 6

Mean scores for the MEACI subscale: Allowing the Child Self-Direction

| | Experimental (n=17) | | Control (n=15) | |
|-----------|---------------------|----------|----------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 22.235 | 10.353 | 22.000 | 22.533 |
| <u>SD</u> | 3.800 | 2.691 | 4.660 | 4.502 |

Total cases= 32

Note. A decrease in the mean score indicates an increase in allowing the child self-direction.

Table 7

Analysis of covariance data for the mean scores on the MEACI subscale: Allowing the Child Self-Direction

| Source of Variation | Sum of Squares | df | Mean Square | F Ratio | Sign. of F | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|---------|------------|----------------|-------------|
| Main effects | 1185.177 | 1 | 1185.177 | 86.852 | .000* | 1.000 | .328 |
| Covariates | 3.884 | 1 | 3.884 | .285 | .598 | .081 | .005 |
| Error | 395.731 | 29 | 13.646 | | | | .175 |
| Corrected total | 1581.875 | | | | | | |

* $p < .001$

Table 7 shows that the F ratio for the main effects was significant to the .001 level, $F(1, 29)=86.852$, $p < .001$, indicating a significant increase in the experimental group parents' behavioral willingness to allow their children self-direction during

observed play sessions. On the basis of this data, hypothesis 1.b was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.328).

Hypothesis 1.c

The experimental parent group will attain a significantly higher mean score on the Involvement subscale of the MEACI posttest than will the control parent group.

Table 8 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 9 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 8

Mean scores for the MEACI subscale: Involvement

| | Experimental (<u>n</u> =17) | | Control (<u>n</u> =15) | |
|-----------------|------------------------------|----------|-------------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 17.235 | 8.529 | 19.067 | 19.533 |
| <u>SD</u> | 4.893 | 3.165 | 5.203 | 5.423 |
| Total cases= 32 | | | | |

Note. A decrease in the mean score indicates an increase in involvement.

Table 9

Analysis of covariance data for the mean scores on the MEACI subscale: Involvement

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 813.534 | 1 | 813.534 | 52.104 | .000* | .529 | .529 |
| Covariates | 119.176 | 1 | 119.176 | 7.633 | .010 | .078 | .078 |
| Error | 452.793 | 29 | 15.614 | | | | .295 |
| Corrected total | 1536.875 | | | | | | |

* $p < .001$

Table 9 shows the *F* ratio for the main effects was significant to the .001 level, *F* (1, 29)=52.104, $p < .001$, indicating a significant increase in the experimental group parents' attention to and participation in their children's play during observed play sessions. On the basis of this data, hypothesis 1.c was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is medium (.529).

Hypothesis 2

The experimental parent group will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) posttest than will the control parent group.

Table 10 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 11 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 10

Mean total scores for the Porter Parental Acceptance Scale (PPAS)

| | Experimental ($n=17$) | | Control ($n=15$) | |
|-----------------|-------------------------|----------|--------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 126.118 | 147.412 | 125.600 | 126.933 |
| <u>SD</u> | 21.154 | 18.895 | 19.120 | 15.971 |
| Total cases= 32 | | | | |

Table 11

Analysis of covariance data for the mean total scores on the Porter Parental Acceptance Scale (PPAS)

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 3318.904 | 1 | 3318.904 | 24.159 | .000* | .997 | .263 |
| Covariates | 5299.151 | 1 | 5299.151 | 38.574 | .000 | 1.000 | .420 |
| Error | 3983.900 | 29 | 137.376 | 137.376 | | | .316 |
| Corrected total | 12624.875 | | | | | | |

* $p < .001$

Table 11 shows the *F* ratio for the main effects was significant to the .001 level, *F* (1, 29)=24.159, $p < .001$ indicating a significant increase in the experimental group parents' acceptance of their children. On the basis of this data, hypothesis 2 was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.263).

Hypothesis 2.a

The experimental parent group will attain a significantly higher mean score on the Respect for the Child's Feelings and Right to Express Them subscale of the PPAS posttest than will the control parent group.

Table 12 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 13 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 12

Mean scores for the PPAS subscale: Respect for the Child's Feelings and Right to Express Them

| | Experimental (n=17) | | Control (n=15) | |
|-----------------|---------------------|----------|----------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 26.882 | 38.588 | 30.400 | 31.467 |
| <u>SD</u> | 6.343 | 6.315 | 7.405 | 5.829 |
| Total cases= 32 | | | | |

Table 13

Analysis of covariance data for the mean scores on the PPAS subscale: Respect for the Child's Feelings and Right to Express Them

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 597.885 | 1 | 597.885 | 23.797 | .000* | .997 | .394 |
| Covariates | 385.247 | 1 | 385.247 | 15.334 | .001 | .966 | .254 |
| Error | 728.604 | 29 | 25.124 | | | | .480 |
| Corrected total | 1518.000 | | | | | | |

* $p < .001$

Table 13 shows the *F* ratio for the main effects was significant to the .001 level, *F* (1, 29)=23.797, $p < .001$, indicating a significant increase in the experimental group parents' respect for their children's feelings and their right to express them. On the basis of this data, hypothesis 2.a was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.394).

Hypothesis 2.b

The experimental parent group will attain a significantly higher mean score on the Appreciation of the Child's Unique Makeup subscale of the PPAS posttest than will the control parent group.

Table 14 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 15 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 14

Mean scores for the PPAS subscale: Appreciation of the Child's Unique Makeup

| | Experimental ($n=17$) | | Control ($n=15$) | |
|-----------------|-------------------------|----------|--------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 30.765 | 33.000 | 31.733 | 32.267 |
| <u>SD</u> | 7.076 | 5.074 | 5.994 | 6.006 |
| Total cases= 32 | | | | |

Table 15

Analysis of covariance data for the mean scores on the PPAS subscale: Appreciation of the Child's Unique Makeup

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 13.119 | 1 | 13.119 | .775 | .386 | .136 | .014 |
| Covariates | 425.711 | 1 | 425.711 | 25.132 | .000 | .998 | .462 |
| Error | 491.222 | 29 | 16.939 | | | | .533 |
| Corrected total | 921.219 | | | | | | |

Table 15 shows the *F* ratio for the main effects was .386 indicating there was not a significant increase in the experimental group parents' appreciation for their children's uniqueness. On the basis of this data, hypothesis 2.b was rejected.

Hypothesis 2.c

The experimental parent group will attain a significantly higher mean score on the Recognition of the Child's Need for Autonomy and Independence subscale of the PPAS posttest than will the control parent group.

Table 16 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 17 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 16

Mean scores for the PPAS subscale: Recognition of the Child's Need for Autonomy

| | Experimental (n=17) | | Control (n=15) | |
|-----------------|---------------------|----------|----------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 37.647 | 41.059 | 38.000 | 38.133 |
| <u>SD</u> | 4.936 | 4.293 | 5.892 | 4.627 |
| Total cases= 32 | | | | |

Table 17

Analysis of covariance data for the mean scores on the PPAS subscale: Recognition of the Child's Need for Autonomy

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 76.957 | 1 | 76.957 | 6.253 | .018* | .676 | .116 |
| Covariates | 237.769 | 1 | 237.769 | 19.320 | .000 | .989 | .359 |
| Error | 356.905 | 29 | 12.307 | | | | .538 |
| Corrected total | 662.875 | | | | | | |

* $p < .05$

Table 17 shows the *F* ratio for the main effects was significant to the .018 level, *F* (1, 29)=6.253, $p < .05$, indicating a significant increase in the experimental group parents' recognition of their children's need for autonomy and independence. On the basis of this data, hypothesis 2.c was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.116).

Hypothesis 2.d

The experimental parent group will attain a significantly higher mean score on the Unconditional Love subscale of the PPAS posttest than will the control parent group.

Table 18 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 19 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 18

Mean scores for the PPAS subscale: Unconditional Love

| | Experimental ($n=17$) | | Control ($n=15$) | |
|-----------------|-------------------------|----------|--------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 30.824 | 34.765 | 25.467 | 26.467 |
| <u>SD</u> | 8.995 | 7.562 | 6.163 | 6.621 |
| Total cases= 32 | | | | |

Table 19

Analysis of covariance data for the mean scores on the PPAS subscale: Unconditional Love

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 152.077 | 1 | 152.077 | 7.342 | .011* | .745 | .073 |
| Covariates | 928.078 | 1 | 928.078 | 44.804 | .000 | 1.000 | .447 |
| Error | 600.714 | 29 | 20.714 | | | | .289 |
| Corrected total | 2077.500 | | | | | | |

* $p < .05$

Table 19 shows the *F* ratio for the main effects was significant to the .011 level, *F* (1, 29)=7.342, $p < .05$, indicating a significant increase in the experimental group parents' unconditional love for their children. On the basis of this data, hypothesis 2.d was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.073).

Hypothesis 3

The experimental parent group will attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will the control parent group.

Table 20 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 21 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 20

Mean Total Scores for the Parenting Stress Index (PSI)

| | Experimental (n=17) | | Control (n=15) | |
|-----------------|---------------------|----------|----------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 260.471 | 245.412 | 239.200 | 249.533 |
| <u>SD</u> | 30.156 | 29.715 | 25.058 | 22.674 |
| Total cases= 32 | | | | |

Table 21

Analysis of covariance data for the mean total scores on the Parenting Stress Index (PSI)

| Source of Variation | Sum of Squares | df | Mean Square | F Ratio | Sign. of F | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|---------|------------|----------------|-------------|
| Main effects | 2430.221 | 1 | 2430.221 | 6.865 | .014* | .717 | .113 |
| Covariates | 11060.191 | 1 | 1060.191 | 31.245 | .000 | .000 | .515 |
| Error | 10265.660 | 29 | 353.988 | | | | .478 |
| Corrected total | 21461.219 | | | | | | |

* $p < .05$

Table 21 shows the F ratio for the main effects was significant to the .014 level, $F(1, 29)=6.865$, $p < .05$, indicating a significant decrease in the experimental group parents' perceived level of stress related to parenting. On the basis of this data, hypothesis 3 was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.113).

Hypothesis 3.a

The experimental parent group will attain a significantly lower mean score on the Parent Domain of the PSI posttest than will the control parent group.

Table 22 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 23 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 22

Mean Scores for the PSI subscale: Parent Domain

| | Experimental ($n=17$) | | Control ($n=15$) | |
|-----------------|-------------------------|----------|--------------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 146.529 | 133.412 | 136.400 | 141.000 |
| <u>SD</u> | 25.377 | 21.866 | 17.249 | 18.295 |
| Total cases= 32 | | | | |

Table 23

Analysis of covariance data for the mean scores on the PSI subscale: Parent Domain

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 1445.863 | 1 | 1445.863 | 6.153 | .019* | .669 | .113 |
| Covariates | 5521.355 | 1 | 5521.355 | 23.496 | .000 | .997 | .432 |
| Error | 6814.762 | 29 | 234.992 | | | | .533 |
| Corrected total | 12794.969 | | | | | | |

* $p < .05$

Table 23 shows the *F* ratio for the main effect was significant to the .019 level, *F* (1, 29)=6.153, $p < .05$, indicating a significant decrease in the experimental group parents' perceived level of stress related to their attitudes and perception of themselves as parents. On the basis of this data, hypothesis 3.a was retained. Using Cohen's (1988) reference for effect size, it is evident that the effect size in the analysis is low (.113).

Hypothesis 3.b

The experimental parent group will attain a significantly lower mean score on the Child Domain of the PSI posttest than will the control parent group.

Table 24 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 25 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores, as well as the observed power and treatment effects.

Table 24

Mean Scores for the PSI subscale: Child Domain

| | Experimental (n=17) | | Control (n=15) | |
|-----------------|---------------------|----------|----------------|----------|
| | Pretest | Posttest | Pretest | Posttest |
| Mean | 113.941 | 112.000 | 102.800 | 108.533 |
| <u>SD</u> | 14.285 | 13.139 | 13.289 | 9.456 |
| Total cases= 32 | | | | |

Table 25

Analysis of covariance data for the mean scores on the PSI subscale: Child Domain

| Source of Variation | Sum of Squares | df | Mean Square | <i>F</i> Ratio | Sign. of <i>F</i> | Observed power | Eta Squared |
|---------------------|----------------|----|-------------|----------------|-------------------|----------------|-------------|
| Main effects | 18.973 | 1 | 18.973 | .197 | .660 | .071 | .005 |
| Covariates | 1219.938 | 1 | 1219.938 | 12.663 | .001 | .930 | .297 |
| Error | 2793.796 | 29 | 96.338 | | | | .680 |
| Corrected total | 4109.500 | | | | | | |

Table 25 shows the *F* ratio for the main effects was .660, indicating there was not a significant decrease in the experimental group parents' perceived level of stress related to their children's behavior. On the basis of these data, hypothesis 3.b was rejected.

Discussion

The results of this study, along with participants' comments and this researcher's observations, provide information regarding the effectiveness of filial therapy training with immigrant Korean parents in the United States. Ten of the 12 hypotheses were retained. An interpretation of all scores is provided in the following section.

Empathy in Parent-Child Interactions

As revealed in Tables 2 through 9, the experimental group parents demonstrated a statistically significant increase in empathic behavior with their children as measured by the Measurement of Empathy in Adult-Child Interaction scale. The experimental group's posttest mean total score decreased 29 points ($SD = 6.7$), while the control group's mean score decreased 1 point ($SD = 10$). It is important to note that a decrease in these scores indicates an increase in empathic behavior. These results are noteworthy because they are based on direct observation of specific skills by a trained professional rather than self-report measures. The experimental group parents demonstrated: (a) an increase in commenting on their child's expression of feeling and behavior in a genuinely accepting manner; (b) an increase in following their child's lead rather than attempting to control their child's behavior; and (c) an increase in being involved fully in their child's play.

Although the parents reported being initially skeptical about the value of the special play time and filial therapy training, they were surprised by their children's positive experiences in the special play times. Because the filial therapy training encouraged these immigrant Korean parents to interact with their children on an emotional level, the mothers learned to communicate with their children as psychological agents. The role of therapeutic agent fits with the Korean mothers' primary responsibility,

which is to be the psychological provider for a child. One mother shared her new learning about her child after two play times with her 7 year old son:

I raised my child for 7 years, but I realized that I had not really known my child until I had special play times with my son. Like peeling an onion, I begin to see new and different aspects of my child more and more in special play times. I was almost shocked by my child because he was a different child. My child was very creative and focused on one activity for a long time in special play times.

A mother of a 10 year old child shared:

When I saw the filial therapy toys, I wondered how my child could play with them because I thought that these toys were for younger children. During the special pretest play time, I forced him to play for 20 minutes, but now my child enjoys the special play time. He always says to me that he wants to be a good cook. During the special play times, he is a cook at a bakery, shows me how to make all kinds of bread, and shares the bread with me. He has been a cook since we started this special play time, and he does not look like he is bored with being a cook over and over. He looks so happy. I am thinking that I should allow him to go to classes at the bakery institute that will be open during summer vacation.

In addition, the experimental group parents reported their children's changed emotions before, during, and after the special play times: relaxation, calming down, excitement, happiness, satisfaction, and less aggressive.

Communication of acceptance. The experimental group demonstrated a significant increase ($p < .001$) on the Communication of Acceptance subscale. This is a subscale measuring the level of acceptance communicated by a parent when commenting

on the child's expression of feelings or behavior. The Korean mother-child relationship is a mo chong relationship. This mo chong is an affective bond of love. A Korean mother tries to empathically relate to her child and understand the child from the child's perspective. However, this mo chong does not automatically lead to communicating the child's feelings or behavior. The researcher's observations in this study and the parents' comments also supported this fact. Many immigrant Korean parents expressed their empathic understanding of their children in the filial therapy trainings. However, they did not share their empathic communication with their children during the special play times in the early stages of filial therapy training. Although immigrant Korean parents acknowledge their children's feelings there are two reasons that may prevent them from communicating their emotions verbally. First, immigrant Korean parents tend to believe that their children already know that they are loved. Second, immigrant Korean mothers have been discouraged from expressing their feelings or opinions by their parents. These immigrant Korean mothers were able to learn to identify and verbally reflect their child's emotions and behaviors through filial therapy training.

The findings of this study on the Communication of Acceptance subscale confirmed that Korean parents were able to communicate their acceptance to their children. They were able to be more congruent with themselves because they learned to communicate their feelings and reactions in a genuine manner. The mother of a 4 year old daughter shared:

My daughter noticed that my communication style was different than usual. When I reflected her feelings, she looked at me and then kept doing what she had been doing in special play time. After the play session, I asked my child if she liked my

comment because I was curious. My child said she liked it and wanted me to communicate in empathic manners all the time.

The mother of a 5 year old daughter shared her struggle to resist asking questions and to instead make accepting comments:

After the filial therapy training, I wanted to see how I could make a difference in my relationship with my child. Thus, one day I communicated to my child in the usual manner. When I picked her up, I asked how her school was. She responded shortly, "good." The next day when I picked her up, I said you look happy, then I stopped right there. I wanted to know more, but I did not ask. It was hard not to ask questions. She just nodded her head. Then, later on, she told me why she was happy and what happened at school. It was an exciting experience. I realized that verbally conveying acceptance of feeling was very effective.

The experimental group parents were able to generalize their communication of acceptance to other children. One mother of a 2 year old daughter and 12 year old son shared:

I wish I could have known this filial therapy training earlier so that I could have used what I learned with my son. Although my child of focus for this training is my 2 year old daughter, I try to reflect my son's feelings and recognize his behaviors too. Interestingly, I noticed that my 12 year old son seemed very jealous of my special play time with his younger sister. At first, I could not understand why he was upset since he is 12 years old. He is a big boy and my daughter is just 2 years old. She is a baby, but now I think he wants to have my attention and love, too. Thus, I try to communicate with him in an empathic

manner to fulfill his needs. He seems better now. I think accepting communication is very important to any child no matter if the child is old or young.

Allowing the child self-direction. The experimental group demonstrated a significant increase ($p < .001$) on the Allowing the Child Self-Direction subscale. This subscale measures a parent's ability to follow his or her child's lead. During supervision, several parents expressed their difficulty in avoiding directing their children. Since Confucianism influences Korean family and social systems by encouraging Korean children to follow and obey their parents, Korean parents tend to direct, give suggestions, and make decisions for their children. This concept of one-sided obedience was challenged by a mother of a 5 year old son who shared how her parents had raised her:

This filial therapy training makes me think of my childhood. It is no exaggeration to say that my personality has been shaped by my parents' hands like a sculpture. When I was young, I was an obedient child. If my parents did not want me to do anything, I did not do it. However, now I am regretful. I believe my life would have been different if my parents had not directed me so much. To my child, I do not want to make the same mistakes that my parents made with me. I want to allow my child to be whatever he wants. I want him to feel free.

Another mother of a 4 year old shared her difficulty with not leading during the special play time:

I was so irritated when my child had difficulty putting a dart into a dart gun. He seemed frustrated and mad because the dart did not click in the gun. Even if it was easy, he had a hard time. I struggled so much because I felt I should have helped

him. I did not take his gun to fix it, but verbally I gave him some suggestions that he could try. I know I should have reflected his frustration and anger because I am not there for my child as a problem solver. Next time I will try to reflect his feelings instead of solving the problem.

Another mother of a 3 year old shared the same struggle:

My child was playing with play dough. Since the play dough was dry, it was hard to make something with it. With his little hands, he tried to roll the play dough to make a snow ball. He seemed focused and did not care about the dry play dough, but I felt I needed to help him and make a nice snow ball for him. I did not help him directly, but I found myself communicating indirectly by pounding the floor.

So, I held my two hands together to not give any information, even nonverbally.

These mothers began to realize what was helpful to their children through filial therapy training. These examples suggest that it is true that immigrant Korean mothers experience struggles because they have a strong need to protect their children from any difficulties and troubles. However, the findings of this study demonstrate that filial therapy training can help immigrant Korean mothers to allow their children to lead and try their own ideas out in special play time.

Involvement. The experimental group demonstrated a significant increase ($p < .001$) on the Involvement subscale. This subscale measures the parents' level of involvement while observing their children. Immigrant Korean parents work very hard to provide better lives for their children. A 30-minute special play time each week seemed helpful to the children. Many of the experimental group parents described their schedules as very busy. They expressed feelings of guilt for not spending time with their children,

and reported physical and emotional exhaustion. They were also concerned that their children might develop behavioral and emotional problems. The filial therapy training helped these immigrant Korean parents to feel less overwhelmed, to put less pressure on themselves, and to feel more confident in parenting. One mother of a 9 year old daughter shared a precious moment and started to weep:

My schedule is usually so tight. Last week, I came back to my home and made a meal for my family. After dinner, I set up a special play time with my daughter. However, right before the special play time, I felt sleepy. I could not focus on my child, and had difficulty recognizing my child's emotions. This week, I came home a little bit early from work. After dinner, I took a break with my child. We spent time listening to music for 30 minutes. During the special play time, I realized that my child was so lovable. I never experienced that before. I could tell my child was also relaxed and looked very happy.

This Korean mother experienced emotional, physical, and verbal involvement with her child through filial therapy. The mother learned the value of relating to her child with undivided attention.

Another mother of a 10 year old son shared:

When I went home, I was too tired to have a special play time with my son. However, I remembered that early that morning my child had made sure that this was special play time day before he went to school. I could not say no to my son, so I had a special play time with my son. I was so tired I could not say a word, but I observed him for 30 minutes. He smiled at me several times and laughed. He seemed so happy. Although I was so tired and did not say anything, I think I did a

good thing because I kept my promise to have a special play time once a week with him.

The significant positive changes indicated by the MEACI measure suggest that filial therapy is an effective treatment for increasing empathy, communication of acceptance, and involvement in parent-child interaction. Parents learn how to allow children to direct their own play. The findings of this study also support Jang's (2000) study. She used a Landreth's (1991) 10-week filial therapy training model with Korean parents in Korea. Jang's study demonstrated a significant increase in parents' empathic behavior with their children as measured by the MEACI scale. The findings in the present study are also similar to those of previous studies (Bratton, 1993; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Guerney & Stover, 1971; Harris & Landreth, 1997; Landreth & Lobaugh, 1998; Yuen, 1997).

Parental Acceptance

As revealed in Tables 10 through 19, the experimental group parents demonstrated statistically significant increases in their perceived acceptance of their children on three of four subscales and on the total score of the Porter Parental Acceptance Scale. The posttest mean total score for the experimental group parents increased by 21 points ($SD = 19$) over the pretest mean total score, while the control group parents' total mean score increased by 1 point ($SD = 16$) over the pretest mean total score. The experimental group parents reported growth in respect for their children's feelings and right to express them, recognition of their children's need for autonomy, and in unconditional love.

Korean mothers take responsibility within the family for the fulfillment of the psychological needs of the children. The Korean mother's accepting bond, mo chong, is better facilitated through filial therapy training because filial therapy helps parents to be aware of their children's emotional needs, and to interact effectively on an emotional level with their children. During the special play sessions, the parents practiced acceptance of their children's feelings and right to express them, and were able to recognize their children's need for autonomy. They also provided nonjudgmental affection to their children. Parental acceptance is facilitated through specific play therapy principles and skills that the parents are required to practice during filial therapy training. During one of the earlier filial therapy sessions, a mother of a 5 year old daughter expressed her concerns about her child because her child did not speak to any adult other than family members and friends:

I feel embarrassed with my child. She is not talking at all at church. She is only talking to her friends and family members. Many people from the church ask me whether or not she can speak. I know that some of them are looking at me as if I am a bad mother. I am so angry at my child. I have punished her for not talking. I have also threatened and coaxed her to make her talk to people at church. I do not want to talk about my child in public because I do not want them to see my child as a problem child.

Through filial therapy, this mother was able to become more accepting of her child. Since filial therapy trains parents to focus on the child instead of the child's problem, this mother developed insight that changed her perception of her child and increased her acceptance toward the child. In the 10th filial therapy session, this mother shared:

I think I thought of my child as a problem when I look back. I also think I tried to fix the "problem," so I began to see the problem as bigger and bigger. I know my child has a lot of strengths, but I was not aware of them at that time. Now, I do not want to put any pressure on my child just because she is not talking to adults at church. I tell my child if you want to talk, yes you can, but if you do not, then you do not have to talk. I want to wait on my child because she needs more time than other children. I talked about this with my husband. He agreed with me. My child is a child. She is not a problem, and I am not a bad mother.

This comment also indicates that this mother began to see herself separately from her child. Korean mothers tend to take responsibility for their children's emotional and behavioral problems. This tendency can cause feelings of guilt which can interfere with their level of confidence as parents. As a result, they may express anger toward their children. In the above case, this mother became aware of her child's unique needs through filial therapy.

This was also the case with another mother who shared:

I changed my perspective toward children because of the filial therapy training. When I saw crying and demanding children in public areas such as at church or in grocery stores, I automatically would say to myself "Who is the mother?" "Why is that child crying like that?" or "How on earth did that mother educate her child?" I criticized the mother and the child. However, I have become accepting of other children as well as of my own child. I talk to myself like this, "They are children, all children cry, and it is natural for children to cry and demand some times."

This mother became more accepting of her child and generalized her parental acceptance to all children.

Respect for the child's feelings and right to express them. The experimental group demonstrated a significant increase ($p < .001$) on the Respect for the Child's Feelings and Right to Express Them subscale. This subscale measures a parent's willingness to demonstrate acceptance of their child, and to allow their child to express feelings. Children of immigrant Korean parents often experience identity conflicts because they are struggling to adjust to two cultures. They experience pressure in school because of their parents' high expectations for academic success. It is essential that immigrant Korean parents respect and understand their children's feelings and opinions to help ease their emotional burden and aid adjustment. This study demonstrated that filial therapy helped immigrant Korean parents to enhance their understanding and acceptance of their children's feelings, needs, and opinions in an empathic manner. A mother of a 6 year old son shared:

To be honest with you, I was not sure how I could change myself with this training at the beginning. However, I feel that I am different than before. I never thought about my child's feelings, opinions, and perspectives because I thought I knew better than my child about my child. I taught him to respect and follow my ideas rather than his own ideas. I think I tried to get him to believe in me more than in himself. Now, I am trying to listen and pay attention to him. My attitude has become more generous and nice. I feel close to my child.

Another mother of an 8 year old daughter shared:

I was so mad when my daughter was talking back to me. When I was a child, I did not talk back to my parents. I obeyed their opinions even if I did not like to do that. I thought, however, my child was so different than I was, and she had to absolutely obey my direction. I felt that she did not respect me as a parent. I thought she was not afraid of me at all. However, I see her differently now. She is expressing what she wants. I try to understand her. She seems to respond to me nicely, too.

Appreciation of the child's unique makeup. The experimental group did not demonstrate a significant increase on the Appreciation of the Child's Unique Makeup subscale, even though their mean score increased 2 points ($SD = 5$), while the control group's mean score indicated no change. This subscale measures a parent's appreciation of and valuing of his or her child's uniqueness. The nonsignificant results can be explained by the nature of the questions that comprise the Appreciation of the Child's Unique Makeup subscale. This subscale primarily measures the degree of parental acceptance as parents compare the behaviors or feelings of their children in situations with other same aged children. The other subscales of the Parental Acceptance scale focus on parental acceptance of the child's behaviors and feelings in a nonsocial context. On these subscales, the experimental group parents demonstrated a significant increase in parental acceptance in their relationships with their children, although when comparing their children to other same aged children on the Appreciation of the Child's Unique Makeup subscale, parental acceptance of their children's behaviors or feelings did not increase significantly. However, as the parents continue to integrate filial therapy training

in play sessions, they may experience more acceptance of their children, and may then generalize this acceptance in social contexts.

Korean parents consider their children to be extensions of themselves. They compensate for their lack of accomplishment through their children. Thus, Korean mothers' personhoods are fused with that of their children. However, in spite of this strong cultural sense of relatedness between a Korean mother and her child, reports and observations of immigrant Korean parents in filial therapy training demonstrated that filial therapy helped immigrant Korean parents become aware of their own needs and of their children's unique needs. A mother of a 7 year old boy shared:

I raised my son to be a good and nice boy, so if he went to school or church, people would think I was a good mother who raised my son as a polite boy.

However, I feel sorry for him now because I shaped his personality. I thought he was like a wild horse when he was young, so I trained him as if I were a tamer.

What I learned from this filial therapy training is to let him be himself and value him as a unique child.

Another mother of a 5 year old son shared:

My child was a quiet and obedient child. When I said "stop", he stopped whatever he was doing because I said so. However, now he seems to have a strong will. He tells me what he wants. He seems like a different child now. I think my child is growing, and he seems more confident in himself.

Child's need for autonomy and independence subscale. The experimental group demonstrated a significant increase ($p < .05$) on the Child's Need for Autonomy and Independence subscale. This scale assesses parental understanding of children's needs to

differentiate and separate from their parents in order to achieve their own identities. The immigrant Korean parents in this study who received filial therapy were able to recognize their children's need for their own identity. A mother of an 8 year old daughter shared:

I realized that there are many things that my child can do. I used to worry about my child a lot. For example, every morning, I yelled at my child to wake her up. If I had not done it, she would have been late and received punishment from her teacher. However, last week after the filial therapy training, I gave my child choices with an alarm clock so she could get up and get ready for school by herself. My child and I also made a rule. If she breaks the rule, she would have to walk back home from school. Since she got up late and could not keep the rule, she was complaining that I did not wake her up. However, I did not criticize and become angry with her because my child was experiencing the consequence of her behavior. As a result of her decision, she lost a ride home from school. That day, she walked back home.

This mother did not take responsibility for her daughter's behavior and feelings. Rather, she set a boundary, and allowed her daughter to follow through her own decision. As a result, this mother encouraged her child to be responsible and independent.

Unconditional love. The experimental group demonstrated a significant increase ($p < .05$) on the Unconditional Love subscale. This subscale measures the ability of a parent to feel affection towards a child without placing conditions or minimum standards on the child. Unconditional love can be related to the concepts of mo chong and om bu ja mo for Korean culture. Americans value "love," and Koreans value "chong." Mo chong is a concept describing the unconditional love and affection parents experience with their

children. Om bu ja mo means a strict father and a benevolent mother. Filial therapy encouraged these immigrant Korean mothers to express this love to their children through learning the value of reflective listening and practicing it in special play times.

The results of the PPAS suggest that a 10-week filial therapy training model is effective in increasing parental acceptance in immigrant Korean parents. The most dramatic increase was obtained on the Respect for the Child's Feelings and Right to Express Them subscale among the PPAS subscales. This result is particularly significant because immigrant Korean parents typically have been discouraged from expressing their feelings and opinions by their parents. The experimental group parents were able to value their own feelings and express them through filial therapy training. They also encouraged their children to be expressive during special play time. These changes may be attributed to the fact that the experimental group parents were encouraged to share their feelings and opinions by a filial therapist in a supportive environment, and to apply this skill during special play times. They also realized that in America individuals place greater value on their feelings and right to express emotions, and that their children would grow up in this more expressive climate.

In this study, the increase in the parents' acceptance of their children may also have resulted from their introduction to play therapy principles. These parents learned to recognize the child rather than identifying the child through perceived problems. They were able to value their children's strengths and capacity to grow. These changed perspectives and attitudes helped these parents to accept more fully their children as they are. These parents are more likely to respect their children's needs and wants instead of imposing their own on their children. These Korean American children may become less

pressured to satisfy their parents' unachieved dreams and desires. They may become more adaptable to new cultures and be better able to adjust to life in a different country.

The results of the PPAS in this study support the findings in Jang's study (2000). The findings in the present study also support earlier studies in filial therapy (Bratton, 1993; Chau & Landreth, 1997; Costas & Landreth, 1999; Glazer-Waldman, Eimmerman, Landreth, & Norton, 1992; Glover & Landreth, 2000; Harris & Landreth, 1997; Landreth & Lobaugh, 1998; Sensue, 1981; Sywulak, 1979; Yuen, 1997)

Parental Stress

As revealed in Tables 20 through 25, the experimental group parents demonstrated a statistically significant decrease in their experienced stress on the Parent Domain subscale and on the total scores on the Parenting Stress Index. The Parent Domain subscale measures levels of stress related to their perception of themselves as parents. The posttest mean total score for the experimental group parents decreased by 16 points ($SD = 30$) over the pretest mean total score, while the control group parents' score increased by 11 points ($SD = 23$) over the pretest mean total score.

Parent domain. The experimental group parents reported a significant decrease ($p < .05$) in the level of stress related to their perceptions of themselves as parents, whereas the control group parents reported increased levels of stress. Although these immigrant Korean mothers had experienced difficulty providing consistent parenting because of their confusion with new cultural values, filial therapy training helped them to feel more competent. They reported that practicing specific parenting skills including reflective listening, tracking, limit-setting, encouraging, choice-giving, and returning responsibility

as well as decision-making during the special play times was beneficial. A mother of a 7 year old daughter shared:

I never thought that my words and behaviors would influence my child that much. I used to yell and spank my child if she did not listen to me. I knew scolding and spanking were bad, but I did not know what else I could do. Now, I am aware of my words and behaviors, and try to practice new parenting skills as much as possible because I know this will be helpful for my child and myself to develop a better relationship.

Another mother of a 2 year old son shared:

I have realized that I am a good mother because I am able to control my feelings, especially anger. I also discovered my potential abilities to relate with my child in new ways. I am proud of myself. I think I am a good mother.

A mother of a 6 year old son shared:

What I learned from this filial therapy training is that it is not too late to start again. Looking back at myself as a parent before this training, I had done bad things. I treated my child based on my mood. I did not think about my child's mood. Now, I am trying to communicate verbally with my child.

Filial therapy provided these immigrant Korean parents with opportunities to explore their mistaken concepts about parenting. In one of the filial therapy training sessions, an immigrant Korean mother expressed her conviction about spanking and described how her parents had spanked her when she behaved badly and why spanking would be helpful for her children. The mother also reported that she would bring several

Bible verses to the next session describing that children should be spanked. However, following this session, this mother did not bring the Bible verses and shared:

I felt so free after the last filial therapy training as if I had made a confession.

Actually, how can we talk about parenting issues and where can we talk about any concerns like my child's bad behavior outside of this filial therapy training? If we do, people would tell us to spank children for not behaving well, and to threaten them or they will not take us seriously. In this special play time I had a special experience with my child. I spent some time not doing anything and taking a rest with my child before the special play time. I realized that my child was lovable, a thought that I had never had.

Obviously, filial therapy training provided support and acceptance for the parents. This mother expressed her feelings and opinions freely in an accepting environment. She explored her ideas deeply and had insight that changed her perspective of her child and her misconceptions about parenting.

These immigrant Korean parents sympathized with one another, became a supportive group, and shared ideas with one another. A common benefit of the group training format reported by the parents was the feeling of connectedness and realization that they were not alone. Living in a different culture, these immigrant Korean parents experienced loneliness. This filial therapy group provided a supportive and encouraging environment for the participating parents.

Supervision by a filial therapist of home play sessions significantly impacted parenting skills. These parents were able to gain insight into their parenting skills by reviewing and discussing their videotaped play sessions. As a result of the training, the

parents became confident in parenting. The results demonstrate that filial therapy can help immigrant Korean parents to decrease their parenting stress levels as they learn specific parenting skills, and practice them at home. This component of filial therapy training helped these parents to generalize and integrate learning into their daily lives. It may be assumed that, with practice, these parents will continue to be successful in communicating and demonstrating their truth in their children. These Korean American children will consequently develop self-esteem, and experience positive relationships with their parents. In this way, conflicts between these parents and their children may decrease.

Child domain. The experimental group's posttest mean scores on the Child Domain subscale did not decrease significantly. However, they did drop 2 points from pretest to posttest while the control group's mean scores increased 6 points from pretest to posttest. The control group parents' increased parental stress may be explained, in part, by the fact that half of the parents were employed full-time, and that posttesting was done two weeks before Christmas holidays which was an extremely busy period for the parents. The experimental groups were comprised of approximately the same percentage of full-time employees as the control group and posttesting was done at the same time. Therefore, during one of the busiest days of the year, the control group parents indicated increased stress levels in response to their children's behavior while the experimental group parents showed decreased levels but not to a significant degree. This decrease can be inferred to have been a result of the filial therapy training. However, the trend may have negatively affected by the stressful time period during which testing took place. The researcher assumes that, as the parents continue to practice parenting skills in play

sessions, the decreased stress levels would stabilize or continue on a downward trend towards significance. As a preventive intervention, filial therapy training may help parents prevent further stress related to their children's behavior. In addition, based on parents' reports, filial therapy training facilitated internal changes in children including increased self-esteem, self-control, long term concentration ability, respect for others, and expression of feelings.

The results of the PSI in the present study suggest that a 10-week filial therapy training model is an effective treatment for decreasing overall parental stress. The findings in the present study are similar to those of other studies (Bratton, 1993; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Guerney & Stover, 1971; Harris & Landreth, 1997; Landreth & Lobaugh, 1998; Yuen, 1997).

Summary

The results of this study, along with the facilitator's observations and feedback from parents, support the effectiveness of filial therapy training for immigrant Korean parents in the United States. Immigrant Korean parents were able to integrate and implement filial therapy skills with their children.

The emphasis on the relationship between parent and child in filial therapy training is effective because the relationship is the key factor through which children grow physically, emotionally, and psychologically. This emphasis is important because the Korean culture values harmonious relationships with others. This relationship-oriented Korean value is encouraged to develop and strengthen in filial therapy training.

Training immigrant Korean parents to be therapeutic agents also fits with the primary role of the Korean mother in Korean culture because Korean mothers are

psychological providers and healers for their children. Filial therapy empowers parents to make changes in the relationships with their children. Parents become aware of their children's strengths and abilities to grow and change, and stop focusing on their weaknesses and problems. In addition, the educational approach in filial therapy helps Korean parents feel less resistant to psychological intervention, become open to new concepts of parenting skills, and learn to apply these skills into their lives as well as during special play times.

These results suggest that immigrant Korean parents in this study were able to be therapeutic agents for their children during the special play times. They learned to satisfy their children's emotional needs, and to provide safe and firm boundaries for their children. Filial therapy helped immigrant Korean parents discover their own strengths and the capacity to change their lives as well as their children's lives.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. Provide filial therapy training to immigrant Korean parents as a preventative or remedial mental health service.
2. Conduct filial therapy training with immigrant Korean fathers to determine the effectiveness of filial therapy.
3. Train more Korean filial therapy facilitators. Most immigrant Korean parents are more open to a facilitator with the same cultural background. This is especially true when immigrant Korean parents have difficulty with English, in which case they may not receive appropriate psychological services from mainstream USA.

4. Conduct a follow-up study to determine the long-term effects of filial therapy on children and parents.
5. In this study emotional and behavioral changes in children were not measured. Further studies are needed to examine changes in children in these areas.
6. The Korean parents in this study were not comfortable with videotaping their play sessions during the pre- and posttesting. If the videotaping could be done in a play room with a two-way mirror, they might be more relaxed.
7. Provide immigrant Korean parents with translated materials for the filial therapy training.

Concluding Remarks

As a minority, immigrant Korean parents with different cultural values face many challenges. Parents often move to the United States for their children's education as well as a better life. They have high expectations of their children and they work long hours for their families. However, many immigrant Korean parents sacrifice present experiences and relationships with children for the sake of happiness in the future.

Filial therapy helps immigrant Korean parents to be therapeutic agents for their children. It helps them regain their own power as parents and restore positive relationships with their children. Parents who provide consistent parenting skills may help their children adjust successfully to life in the United States. This study demonstrated the effectiveness of filial therapy with immigrant Korean parents in the United States.

APPENDIX A
PARENTING CLASS/RESEARCH INFORMATION
AND CONSENT FORMS

PARENTING CLASS—RESEARCH INFORMATION

You are invited to participate in a study to determine the effectiveness of Filial Therapy training with Korean immigrant parents. You will be asked to complete three questionnaires before and after the training. You will also be asked to participate in a 20-minute videotaped play session with your child before and after training.

Filial Therapy is a family skills training program that focuses on enhancing the parent-child relationship. The training will consist of ten weekly training sessions, lasting two hours per week. During these sessions Mi-Kyong Lee will be teaching you and other parents some techniques on how to interact with your child in ways that are designed to enhance your child's self-esteem as well as strengthen your relationship with your child. Also, you will be asked to share some insights, feelings, questions, and comments with other parents in the group during the sessions. You will also be asked to participate in seven weekly 30-minute play sessions at home with your child practicing the techniques being taught in the training sessions. You will be asked to select one of your children (between the ages of 2-10 years) to focus on during the 10 weeks of training.

There is no personal risk or discomfort directly involved with this study. You will be asked to give some of your time and be willing to explore some new ideas and feelings related to the parenting of your child. There may be times during the play sessions when your child could express sadness, anger, or frustration. While these sessions cannot avoid these situations, neither will they increase the emotion. In fact, the training should help you deal with these situations more effectively. Your participation and your child's participation are completely voluntarily.

All information you provide when you answer the questionnaire will be kept confidential. Names of parents and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the investigator, Mi-Kyong Lee will have a list of the participants' names. At the conclusion of the study, the list of participants' names will be destroyed. The video-taped play sessions of you and your child will be viewed only by graduate research assistants. The research assistants will have no knowledge of participants' names and they will be made aware that the confidentiality of participants is to be maintained. The video tapes will be destroyed upon the completion of this study.

If you agree to participate, please fill out and sign this consent form. For further information, please contact, Mi-Kyong at (940) 383-0741

PARENTING CLASS

Informed Consent

You are making a decision whether or not to participate in this study. You should sign only when you understand all the information presented on the front of this form and all your questions about the research have been answered to your satisfaction. Your signature indicates that you meet all the requirements for participation as explained by Mi-Kyong Lee and have decided to participate, having read the information on the front of this form.

| | | |
|------------------------------------|--------------|---------------|
| _____ Signature of Subject | _____ Age | _____ Date |
| _____ Name of Child of Focus | _____ Age | _____ Date |
| _____ Signature of Witness | _____ Age | _____ Date |
| _____ Signature of Investigator | _____ Age | _____ Date |

CHILD'S FORM

Informed Consent

I understand that I am going to be part of a project with my mom and/or my dad. Mi-Kyong Lee has told me about the things that will happen at the beginning and the end of the project. I will be video-taped playing with my mom and/or dad for 20 minutes each time. My mom and/or dad will be taking some classes to learn how to play with me in some new ways. For seven weeks, I will have special play sessions with my mom and/or dad in my home for 30 minutes once each week. I understand that I can stop taking part in this project at any time I choose.

My “mark” means that I understand what Mi-Kyong Lee has explained to me and that I am willing to be part of this project.

Signature of Subject

Age

Date

Name of Child of Focus

Age

Date

Signature of Witness

Age

Date

Signature of Investigator

Age

Date

APPENDIX B

MEASUREMENT OF EMPATHY IN ADULT-CHILD INTERACTION

RATING FORM

MEASUREMENT OF EMPATHY IN ADULT-CHILD INTERACTION

Rating Form

| | |
|--------|-------------------|
| Rater: | Video Tape Code # |
|--------|-------------------|

Communication of Acceptance: verbal expression of acceptance / rejection

1. Verbally Conveys Acceptance of Feelings. *You're proud of..., You really like..., That makes you angry...*
2. Verbally Recognizes & Accepts Behavior Only (tracking, giving credit): *You got it that time, Your hitting the..., You really stabbed...*
3. Social or No Conversation: *Mothers aren't very good at that. These are nice toys.*
4. Slight to Moderate Verbal Criticism: *No, not that way. You'll have to be more careful. That's cheating. You'll ruin the paints*
5. Strongly Critical / Preaching / Rejecting: *You see, I told you to do it the other way, It's not nice to feel/say..., How stupid! You're being nasty.*

Allowing the Child Self-Direction: behavioral willingness to follow the child's lead (rather than control the child's behavior).

1. Follows the Child's Lead (no verbal comment necessary): *You'd like me to..., I'm supposed to..., Show me what you want me... (whisper tech.)*
2. Allows Child Option for Lead-Taking but asks / volunteers info: gives praise: *What shall we do? "Good", You can shoot this. You did it right.*
3. Adult Takes Lead (teaching child how to do): *Are you sure that's how..., See if you can do..., It might work better...*
4. Directs or Instructs Child (initiates new activity): *Put the doll away first, Why don't you..., Let's play..., Don't put the...*
5. Persuades, Demands, Interrupts, Interferes, Insists: *No, take this one, That's enough, I told you not to..., You've got to...*

Involvement: adult's attention to and participation in the child's activity (may not always contribute in a positive way)

1. Fully Observant (more attention to child than to objects being used): *involved verbally and with "eyes" (& physically when invited by child)*
2. High Level of Attention (attention to activity rather than child): *when adult more involved in game than attending to child's reactions/behaviors*
3. Marginal Attention: *no joint activity, adult involved in own activity to degree that it interferes with attentiveness occasionally comments on child's activity*
4. Partially Withdraw / Preoccupied: *infrequently observes, but doesn't comment, fails to attend to child's needs but responds when asked by child.*
5. Self-involved / Shut Off: *child ignored for prolonged period, child must repeat or prompt to get a response.*

DIRECTIONS FOR SCORING: A rating is made every 3 minute interval for 6 intervals (scoring is retrospective)
(Highest score = 1; Lowest score = 5)

| Communication of Acceptance | 1 | 2 | 3 | 4 | 5 | 6 | Total | Score/Avg Total |
|-----------------------------|---|---|---|---|---|---|-------|-----------------|
| Score Highest Level | | | | | | | | |
| Score Lowest Level | | | | | | | | |
| Comments | | | | | | | | |

| Allowing Self Direction | 1 | 2 | 3 | 4 | 5 | 6 | Total | Score/Avg Total |
|-------------------------|---|---|---|---|---|---|-------|-----------------|
| Score Lowest Level | | | | | | | | |
| Comments | | | | | | | | |

| Communication of Acceptance | 1 | 2 | 3 | 4 | 5 | 6 | Total | Score/Avg Total |
|-----------------------------|---|---|---|---|---|---|-------|-----------------|
| Score Lowest Level | | | | | | | | |
| Comments | | | | | | | | |

| Empathy Score | Grand Total |
|---------------|-------------|
| Comments | |

This form was adapted by Bratton (1993) from Stover, B. Guernsey, and O'Connell (1971).

APPENDIX C

LETTER OF PERMISSION TO USE

PORTER PARENTAL ACCEPTANCE SCALE

BLAINE R. PORTER 1675 PINE LANE
PROVO, UTAH 84604-2163 Tel (801)
377-2411 Fax (801) 375-5115 E-Mail
brporter@cougar.netutah.net

July 31, 2001

MI-KYONG LEE (MONICA LEE), NCC, LPC-1
Ph.D. Candidate in Counselor Education
University of North Texas
308 Bradley St. #3
Denton, TX 76201

Dear Ms Lee:

I was pleased to learn of your interest in using my Parental Acceptance Scale. I hereby grant you permission to use it. For your convenience I am enclosing a copy of the latest revision, Instructions for administering it and a Scoring Key.

If it proves to be of use to you in your research, I will appreciate your sending me a copy of the results of your study.

Best wishes to you in your research project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Blaine R. Porter', with a horizontal line extending to the right.

Blaine R. Porter, Ph.D.

BRP\rms

Enclosures

APPENDIX D

PORTER PARENTAL ACCEPTANCE SCALE

PORTER PARENTAL ACCEPTANCE SCALE

We are seeking information about parent-child relationships. You can help us filling out the following questionnaire frankly and carefully. Sincere and honest answers are requested so that valid data may be obtained.

The questionnaire does not call for any mark of identification your answers along with all others will be absolutely anonymous. Furthermore, all of the responses will be treated confidentially and will be used only for purposes of scientific research.

It is essential that all questions be answered. If you do not closely describes your feelings or actions.

GENERAL INFORMATION

1. Sex: Male _____ Female _____
2. Year of Birth _____
3. Year of Marriage _____
4. Living with spouse at present time Yes _____ No _____
5. Married more than once Yes _____ No _____
6. If married more than once, was previous marriage ended because of
_____ death _____ divorce _____ other (please state) _____
7. Draw a circle around the number of years of schooling you have completed.
12345678 1234 1234 1234
Graduate school High school College Post graduate
8. Religious Affiliation:
_____ Protestant _____ Jewish _____ None
_____ Catholic _____ Other _____
9. Was your childhood and adolescence, for the most part, spent in:
_____ open country or village under 1,000 _____ a town of 1,000 to 4,999
_____ a city of 5,000 to 9,999 _____ a city of 10,000 to 49,999
_____ a city of 50,000 to 99,999 _____ a city of 100,000 to 249,999
_____ a city of 250,000 or over
10. Presently family income (annual)
_____ under \$15,000 _____ \$15,000 to \$24,999
_____ \$25,000 to \$34,999 _____ \$35,000 to \$49,999
_____ \$50,000 to \$74,999 _____ \$75,000 to \$99,999
_____ \$100,000 or more
11. Husband's occupation (Be specific such as computer specialist, CPA, salesperson, teacher, auto mechanic, lawyer, etc.)

12. Wife's occupation (Be specific as illustrated above)

13. Ages of children (to nearest birthday)
Ages of boys _____; _____; _____; _____;
Ages of girls _____; _____; _____; _____;

While responding to the following questions' please think of only one child. If you have a child in the age of six to ten years, choose that one. If you have more than one children that age range, choose the one nearest to ten. If your children are all younger than six years, choose the one nearest six. Place a circle around the age (in question 13 above) of the one which you will be thinking of while answering the questions about your child. **Be sure and refer only to this child while answering the questions.**

14. Is this child your: (circle one)
Biological child Step child Adopted child

Copyright Blaine R. Porter Ph.D.

INFORMATION ABOUT YOUR CHILD

Many parents say that their feeling of affection toward or for their child varies with his/her behavior and with circumstances. Please read each item carefully and place a check in the column which most nearly describes the degree of feeling of affection which you have for your child in that situation.

| Check One Column For Each Item Below | Degree of Feeling of Affection | | | | |
|---|--------------------------------|--------------------------|----------|--------------------------|----------------------|
| | Much more than usual | A little more than usual | The same | A little less than usual | Much less than usual |
| 1. When my child is obedient. | | | | | |
| 2. When my child is with me. | | | | | |
| 3. When my child misbehaves in front of special guests. | | | | | |
| 4. When my child expresses unsolicited affection. You've the nicest mommy/daddy in the whole world. | | | | | |
| 5. When my child is away from me. | | | | | |
| 6. When my child shows off in public. | | | | | |
| 7. When my child behaves according to my highest expectations. | | | | | |
| 8. When my child expresses angry and hateful things to me. | | | | | |
| 9. When my child does things I have hoped my child would not do. | | | | | |
| 10. When we are doing things together. | | | | | |

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

Read each statement carefully and then place a circle around the number in front of the one response which most nearly describes the feeling you usually have or the course of action you most generally take when your child says or does these things.

It is possible that you may find a few statements which describe a type of behavior which you have not yet experienced with your child. In such cases, mark the response which most nearly describes how you think you would feel or what you think you would do.

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:

- a. feel annoyed.
- b. want to know more about what excites my child.
- c. feel like punishing my child.
- d. feel that I will be glad when my child is past this stage.
- e. feel like telling my child to stop.

12. When my child misbehaves while others in the group are behaving well, I:

- a. see to it that my child behaves as the others.
- b. tell my child it is important to behave well when in a group.
- c. let my child alone if the others are not disturbed by the behavior.
- d. ask my child to suggest an alternate behavior
- e. help my child find an alternate behavior to enjoy while not disturbing the group.

13. When my child is unable to do something which I think is important for him/her, I:

- a. want to help my child find success in other things.
- b. feel disappointed in my child.
- c. wish my child could do it.

- d. realized that my child can not do everything.
 - e. want to know more about the things my child can do.
14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
- a. realized that my child is growing up.
 - b. am pleased to see my child's interests widening to other people.
 - c. feel resentful.
 - d. feel that my child doesn't appreciate what I have done for him/her.
 - e. wish my child liked me more.
15. When my child is faced with two or more choices and has to choose only one, I:
- a. tell my child which choice to make and why.
 - b. think it through with my child.
 - c. point out the advantages and disadvantages of each, but let my child decide.
 - d. tell my child that I am sure he/she can make a wise choice and help my child foresee the consequences.
 - e. make the decision for my child.
16. When my child makes decisions without consulting me, I:
- a. punish my child for not consulting me.
 - b. encourage my child to make many of his/her own decisions.
 - c. allow my child to make many of his/her own decision.
 - d. suggest that we talk it over before he/she makes the decision
 - e. tell my child he/she must consult me first before making a decision.
17. When my child kicks, hit, or knocks his/her things about, I:
- a. feel like telling my child to stop.
 - b. feel like punishing him/her.
 - c. am pleased that my child feels free to express himself/herself.
 - d. feel that I will be glad when my child is past this stage.
 - e. feel annoyed.
18. When my child is not interested in some of the usual activities of his/her age group, I:
- a. realize that each child is different.
 - b. wish my child were interested in the same activities.
 - c. feel disappointed in my child.
 - d. want to help my child find ways to make the most of his/her interests.
 - e. want to know more about the activities in which my child is interested.
19. When my child acts silly and giggly, I:
- a. tell my child I know how he/she feels.
 - b. pay no attention to him/her.
 - c. tell my child he/she shouldn't act that way.
 - d. make my child quit.
 - e. tell my child it is all right to feel that way, but help him/her find other ways of expression.
20. When my child prefers to do things with his/her friends rather than with the family, I:
- a. encourage my child to do things with his/her friends.
 - b. accept this as part of his/her growing up.
 - c. plan special activities so that my child will want to be with the family.
 - d. try to minimize his/her associations friends.
 - e. make my child stay with the family.
21. When my child disagrees with me about something which I think is important, I:
- a. feel like punishing him/her.
 - b. am pleased that my child feels free to express his/her thoughts and feelings.

- c. feel like persuading my child that my way is best.
 - d. realize my child has ideas of his/her own.
 - e. feel annoyed.
22. When my child misbehaves while others in his/her group are behaving well, I:
- a. realize that my child does not always behave as others in his/her group.
 - b. feel embarrassed.
 - c. want to help my child find the best ways to express his/her feelings.
 - d. wish my child would behave like the others.
 - e. want to know more about his/her feelings.
23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
- a. give my child something quiet to do.
 - b. tell my child that I wish he/she would stop.
 - c. make my child be quiet.
 - d. let my child tell me about what is so exciting.
 - e. send my child somewhere else.
24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
- a. try to minimize my child's association with that person.
 - b. let my child have such associations when I think he/she is ready for them.
 - c. do some special things for my child to remind him/her of how nice I am.
 - d. point out the weaknesses and faults of the other person(s).
 - e. encourage my child to create and maintain such associations.
25. When my child says angry and hateful things about me to my face, I:
- a. feel annoyed.
 - b. feel that I will be glad when my child is past this stage.
 - c. am pleased that my child feels free to express himself/herself.
 - d. feel like punishing my child.
 - e. feel like telling my child not to talk that way to me.
26. When my child shows a deep interest in something I don't think is important, I:
- a. realize my child has interests of his/her own.
 - b. want to help my child find ways to make the most of this interest.
 - c. feel disappointed in my child.
 - d. want to know more about my child's interests.
 - e. wish my child were more interested in the things I think are important for him/her.
27. When my child is unable to do some things as well as others in his/her group, I:
- a. tell my child he/she must try to do as well as the others.
 - b. encourage him/her to keep trying.
 - c. tell my child that no one can do everything well.
 - d. call attention to the things he/she does well.
 - e. help my child make the most of the activities which he/she can do well.
28. When my child wants to do something which I am sure will lead to disappointment for him/her, I:
- a. occasionally let my child carry such an activity to its conclusion.
 - b. don't let my child do it.
 - c. advise my child not to do it.
 - d. help my child with it in order to ease the disappointment.
 - e. point out what is likely to happen.
29. When my child acts silly and giggly, I:
- a. feel that I will be glad when he/she is past this stage.
 - b. am pleased that my child feels free to express himself/herself.

- c. feel like punishing my child.
 - d. feel like telling him/her to stop.
 - e. feel annoyed.
30. When my child is faced with two or more choices and has to choose only one, I:
- a. feel that I should tell my child which choice to make and why.
 - b. feel that I should point out the advantages and disadvantages of each.
 - c. hope that I have prepared him/her to choose wisely.
 - d. want to encourage my child to make his/her own choices.
 - e. want to make the decision for my child.
31. When my child unable to do something which I think is important for him/her, I:
- a. tell my child he/she must do better.
 - b. help my child make the most of the things which he/she can do.
 - c. ask my child to tell me more about the things which he/she can do.
 - d. tell my child that no one can do everything.
 - e. encourage him/her to keep trying.
32. When my child disagrees with me about something which I think is important, I:
- a. tell my child he/she should not disagree with me.
 - b. make my child quit.
 - c. listen to my child's side of the issue and change my mind if that seems reasonable.
 - d. tell my child maybe we can do it his/her way another time.
 - e. explain that I am doing what is best for him/her.
33. When my child is unable to do some things as well as others in his/her group, I:
- a. realize that my child can't do as well as others in everything.
 - b. wish that my child could do as well.
 - c. feel embarrassed.
 - d. want to help my child find success in the things he/she can do well.
 - e. want to know more about the things my child can do well.
34. When my child makes decisions without consulting me, I:
- a. hope that I have prepared my child adequately to make his/her decisions.
 - b. wish that my child would consult me.
 - c. feel disturbed.
 - d. want to restrict his/her freedom.
 - e. am pleased to see that as my child grows, I am needed less.
35. When my child says angry and hateful things about me to my face, I:
- a. tell my child it is all right to feel that way, but help him/her find other ways to express himself/herself.
 - b. tell my child I know how he/she feels.
 - c. pay no attention to him/her.
 - d. tell my child he/she shouldn't say such things to me.
 - e. make my child quit.
36. When my child kicks, hits, and knocks his/her things about, I:
- a. make my child quit.
 - b. tell my child it's alright to feel that way, but help him/her find other ways of expressing him/herself.
 - c. tell my child he/she shouldn't do such things.
 - d. tell my child I know how he/she feels.
 - e. pay no attention to him/her.
37. When my child prefers to do things with friends rather than with the family, I:

- a. wish my child would spend more time with us.
 - b. feel resentful.
 - c. am pleased to see my child's interests widening to other people.
 - d. feel my child doesn't appreciate us.
 - e. realize that he/she is growing up.
38. When my child wants to do something which I am sure will lead to disappointment, I:
- a. hope that I have prepared him/her to meet disappointment.
 - b. wish that my child did not have to experience unpleasant events.
 - c. want to keep my child from doing it.
 - d. realize that occasionally such an experience will be good for him/her.
 - e. want to postpone these experiences.
39. When my child is not interested in some of the usual activities of his/her age group, I:
- a. help my child realize that it's important to be interested in the same things as others in the group.
 - b. call attention to the activities in which he/she is interested.
 - c. tell my child it is all right not to be interested in the same things as others in his/her group.
 - d. see to it that my child does the same things as others in his/her group.
 - e. help my child find ways of making the most of his/her interests.
40. When my child shows a deep interest in something I don't think is important, I:
- a. let my child go ahead this interest.
 - b. ask my child go tell more about this interest.
 - c. help my child find ways to make the most of this interest.
 - d. do everything I can do discourage my child's interest in it.
 - e. try to interest him/her in more worthwhile things.

THANK YOU VERY MUCH FOR YOUR COOPERATIONS

REFERENCES

- Abidin, R. (1983). Parenting Stress Index. Charlottesville, VA: Pediatric Psychology Press.
- Andronico, M. & Guerney, B. (1967). The potential application of filial therapy to the school situation. Journal of School Psychology, 6 (1), 2-7.
- Andronico, M. P., Fidler, J., Gureney, B., & Guerney, L. F. (1969). The combination of didactic and dynamic elements in filial therapy. In B. G. Guerney (Ed.), Psychotherapeutic agents: New roles for non-professionals, parents, and teachers. (pp. 129-136). New York: Holt, Rhinehart, and Winston.
- Axline (1947). Play therapy: The inner dynamics of childhood. Cambridge, MA: Houghton Mifflin.
- Baggerly, J. (1999). Adjustment of Kindergarten children through play sessions facilitated by fifth grade students trained in child-centered play therapy procedures and skills (Doctoral dissertation, University of North Texas, 1999). Dissertation Abstracts Interantional, 60/06, 1918A.
- Baurch, D. (1949). New ways to discipline. New York: McGraw-Hill.
- Bavin-Hoffman, R., Jennings, G., & Landreth, G. (1996). Filial therapy: Parental perceptions of the process. International Journal of Play Therapy, 5 (1), 45-58.
- Burchinal, L., Hawkes, G., Garner, B. (1957). The relationship between parental acceptance and adjustment of children. Child Development, 28, 67-77.
- Bratton, S., & Landreth, G. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. International Journal of Play Therapy, 4 (1), 61-80.

Bratton, S. C., Ray, D., & Moffit, K. (1998). Filial/family play therapy: An intervention for custodial grandparents and their grandchildren. Educational Gerontology, 24, 391-406.

Brown, C. (2000).). Filial therapy training with undergraduate teacher trainees: child-teacher relationship training. Unpublished doctoral dissertation, North Texas State University, Denton, TX.

Chau, I. Y., & Landreth, G. L. (1997). Filial therapy with Chinese parents: Effects on parental empathic interactions, parental acceptance of child and parental stress. International Journal of Play Therapy, 6 (2), 75-92.

Choi, S. (1998). Korean and Euro-American perspectives of family discipline: Implications for the helping professions. Unpublished doctoral dissertation, The California School of Professional Psychology, Alameda.

Chu, H. (1993). The Korean Americans: Multiethnic reminder. National 4-H Council, Chevy Chase, MD. (ERIC Document Reproduction Service No. ED 371 106).

Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.) Hillsdale, NJ: Lawrence Erlbaum Associates.

Costas, M. B., & Landreth, G. L. (1999). Filial therapy with non-offending parents of children who have been sexually abused. International Journal of Play Therapy, 8 (1), 43-66.

Freud, A. (1952). The role of bodily illness in the mental life of children. In R. S. Eissler, A. Freud, H. Hartmann, & E. Kris (Eds.), *The psychoanalytic study of the child*, VOL VII. (pp. 69-81). New York: International Universities Press.

- Freud, S. (1959). Analysis of phobia in a five-year-old boy. Collected papers: Case histories. New York: Basic Books.
- Fuchs, N. R. (1957). Play therapy at home. Merrill-Palmer Quarterly, 3, 89-95.
- Gilmore, J. (1971). The effectiveness of parental counseling with other modalities in the treatment of children with learning disabilities. Journal of Education, 154, 74-82.
- Ginsberg, B. G. (1976). Parents as therapeutic agents: The usefulness of filial therapy in a community mental health center. American Journal of Community Psychology, 4 (1), 47-54.
- Glass, N. M. (1986). Parents as therapeutic agents: A study of the effects of filial therapy. Unpublished doctoral dissertation, North Texas State University, Denton, TX.
- Glazer-Waldman, H. R. (1991). Filial therapy: CPR training for families with chronically ill children. Unpublished master's thesis. University of North Texas, Denton, TX.
- Glazer-Waldman, H., Zimmerman, J., Landreth, G., & Norton, D. (1992). Filial therapy: An intervention for parents of children with chronic illness. International Journal of Play Therapy, 1 (1), 31-42.
- Glover, G. J., & Landreth, G. (2000). Filial therapy with Native Americans. International Journal of Play Therapy, 9 (2), 57-80.
- Guerney, B. (1964). Filial therapy: Description and rationale. Journal of Consulting Psychology, 28 (4), 304-310.
- Guerney, B. (1977). Relationship enhancement: Skill training programs for therapy, problem prevention, and enrichment. San Francisco: Josey-Bass.

- Guerney, B., & Fluman, A. (1970). Teachers as psychotherapeutic agents for withdrawn children. Journal of School Psychology, 8, 107-113.
- Guerney, B., Guerney, L., Andronico, M. P. (1966). Filial therapy. Yale Scientific Magazine, 40, 6-14.
- Guerney, B., & Stover, L. (1971). Filial therapy: Final report on MH 18254-01. Unpublished manuscript: The Pennsylvania State University.
- Guerney, L. F. (1975). Brief follow-up study on filial therapy. Paper presented at the Eastern Psychological Association, New York City.
- Guerney, L. F. (1976). Filial therapy program. In D. Olsen (Ed.), Treating relationships. (pp. 67-91). Take Mills, IA: Graphic Publish.
- Guerney, L. F. (1983). Introduction to filial therapy: Training parents as therapists. In P. A. Keller, & L. G. Ritt (Eds.), Innovations in clinical practice: A source book. (pp. 26-39). Sarasota, FL: Professional Resource Exchange.
- Harris, Z. L., & Landreth, G. L. (1997). Filial therapy with incarcerated mothers: A five weeks model. International Journal of Play Therapy, 6 (2), 53-73.
- Harter, S. (1982). The perceived competence scale for children, Child Development, 53, 87-97.
- Harter, S. (1985). Manual for the self-perception profile for children. Denver, Co: University of Denver.
- Harter, S., & Pike, R. (1984). The pictorial scale of perceived competence and social acceptance for young children. Child Development, 55, 1969-1982.

Hauenstein, E., Scarr, S., & Abidin, R. (1986). Measurement of parental stress across cultures: validation of the Parenting Stress Index with American and Bermudian parents. Unpublished manuscript, University of Virginia.

Horner, P. L. (1974). Dimensions of child behavior as described by parents: A monotonicity analysis. Unpublished master's thesis, The Pennsylvania State University, University Park, PA.

Hornsby, L., & Applebaum, A. (1978). Parents as primary therapists: Filial therapy. In L. Arnold (Ed.), *Helping parents help their children* (pp. 126-134). New York: Brunner & Mazel.

Hurn, W. M. (1993). The "1.5 generation": A paragon of Korean-American pluralism. Korean culture, 14, 17-27.

Hurh, W. M. (1998). The Korean Americans. Westport, CT: Greenwood Press.

Jang, M. (2000). Effectiveness of filial therapy for Korean parents. International Journal of Play Therapy, 9 (2) 21-38.

Johnson, L. (1995). Filial therapy: A bridge between individual child therapy and family therapy. Journal of Family Psychotherapy, 6 (3), 55-70

Jones, L. D. (2001). Effectiveness of filial/play therapy training on high school students' empathic behavior with young children. Unpublished doctoral dissertation, University of North Texas, Denton, TX..

Kim, K. (1998). Parental warmth, control, and involvement in schooling in relation to Korean American adolescents' academic achievement. Unpublished doctoral dissertation, Syracuse University, New York.

Kim, U. & Choi, S. H. (1994). Individualism, collectivism, and child development: A Korean perspective. In P. M. Greenfield & R. R. Cocking. (Eds.), Cross-cultural roots of minority child development (p. 227-257). Hillsdale, NJ: Lawrence Erlbaum Associates.

Kim, C. C. & Miura, I. T. (1999). A study of the relationships between acculturation, cultural identity, family bonding, and parent-child conflict among the Korean-American Adolescents. Quebec, Canada: American Educational Research Association. (ERIC Document Reproduction Service No. ED 032 976).

Kim, B. C., Sawdy, M. R., & Meihoefer, B. C. (1982). Facilitation roles with non-native Korean American children. Social Work in Education, 4 (2), 17-33.

Kot, S. (1995). Intensive play therapy with child witnesses of domestic violence. Unpublished doctoral dissertation. University of North Texas, Denton. TX.

Lebovitz, C. (1983). Filial therapy with incarcerated parents. Unpublished doctoral dissertation, Texas Tech University, Lubbock, TX.

Landreth, G. L. (1991). Play therapy: The art of the relationship. Muncie, In: Accelerated Development Press.

Landreth, G. L. & Lobaugh, F. A. (1998). Filial therapy with incarcerated fathers: Effects on parental acceptance of child, parental stress, and child adjustment. Journal of Counseling and Development, 76, 157-165.

Lee, K. Sl. (1996). Culture and the Korean kindergarten curriculum. Early Child Development and Care, 123, 167-182.

- Lee-Oh, J. (1994). A study of the effect of the parenting style by Korean-American parents on their adolescent children's psychological adjustment. Unpublished doctoral dissertation, California School of Professional Psychology, Los Angeles.
- Mangiafico, L. (1988). A short history of Korean immigration to the United States. In L. Mangiafico (Ed.), Contemporary American immigrants: Patterns of Filipino, Korean, and Chinese settlement in the United States. (pp. 77-83). New York: Praeger.
- Min, P. G. (1995). Korean Americans. In P. G. Min (Ed.), Asian Americans: Contemporary trends and issues. (pp. 199-231). Thousand Oaks, CA: Sage Publications.
- Min, P. G. (1998). The Korean-American family. In C. H. Mindel, R. W. Habenstein, & R. Wright, Jr. (4th Eds.), Ethnic families in America: Patterns and variations. (pp. 223-253). Upper Saddle River, NJ: Prentice Hall.
- Moustakas, C. (1959). Psychotherapy with children: The living relationship. New York: Harper and Row.
- Muehl, D. (1961). A manual for coders. Ann Arbor, MI: University of Michigan.
- Oxman, L. K. (1971). The effectiveness of filial therapy: A controlled study (Doctoral dissertation, Rutgers University, 1971). Dissertation Abstracts International, 32 (11), B6656.
- Park, E. K. (1994). Educational needs and parenting concerns of Korean-American parents. Psychological Reports, 75, 559-562.
- Park, I. H. & Lee-Jay, C. (1995). Confucianism and the Korean family. Journal of Comparative Family Studies, 26 (1), 117-134.

Payton, I. (1980). Filial therapy as a potential primary preventive process with children between the ages of four and ten. Unpublished doctoral dissertation, University of Northern Colorado, Dissertation Abstracts International, 41 (01), 2942A.

Porter, B. (1954). Measurement of parental acceptance of children. Journal of Home Economics, 46, 176-182.

Rhee, S. (1996). Effective social work practice with Korean immigrant families. Journal of Multicultural Social Work, 4 (1), 49-61.

Rohner, R. P. & Pettengill, S. M. (1985). Perceived parental acceptance-rejection and parental control among Korean adolescents. Child Development, 56, 524-528.

Ryu, J. P. & Vann, B. H. (1992). Korean families in American. In M. E. Procidano, & C. B. Fisher (Eds.), Contemporary families: A handbook for school professionals. (pp. 117-134). New York: Teachers College Press.

Sensue, M. E. (1981). Filial therapy follow-up study: Effects on parental acceptance and child adjustment (Doctoral dissertation, The Pennsylvania State University, 1981). Dissertation Abstracts International, 42 (01), 0148A.

Shah, S. (1969). Training and utilizing a mother as the therapist for her child. In B. Guerney (Ed.), Psychotherapeutic agents: New roles for nonprofessional, parents, and teachers (pp. 510-517). New York: Holt, Rinehart, and Winston.

Smith (2000). A comparative analysis of intensive filial therapy, intensive individual play therapy and intensive sibling group play therapy with child witnesses of domestic violence. Unpublished doctoral dissertation. University of North Texas, Denton.

Stover, L. & Guerney, B. (1967). The efficacy of training procedures for mothers in filial therapy. Psychotherapy: Theory, Research, & Practice, 4 (3), 110-115.

Stover, L. Guerney, B., & O'Connell, M. (1971). Measurement of acceptance, allowing self-direction, involvement, and empathy in adult-child interaction. Journal of Psychology, 77, 261-269.

Sywulak, A. E. (1979). The effect of filial therapy on parental acceptance and child adjustment (Doctoral dissertation, The Pennsylvania State University, 1978). Dissertation Abstracts International, 38 (12), 6180B.

Tew, K. L. (1997). The efficacy of filial therapy with families with chronically ill children. Unpublished doctoral dissertation, The University of North Texas. Denton. TX.

Therrien, M. E. (1979). Notes for practice: Evaluating empathy skill training for parents. Social Work, 417-149.

Tyndall-Lind, A. (1999). A comparative analysis of intensive individual play therapy and intensive sibling group play therapy with child witness of domestic violence (Doctoral dissertation, University of North Texas, 1999). Dissertation Abstracts International, A 60 (05)

VanFleet, R. (1992). Using filial therapy to strengthen families with chronically ill children. In L. Vandecreek, S. Knapp, & T. L. Jackson (Eds.), Innovations in clinical practice: A source book. Sarasota, FL: Professional Resource Press.

VanFleet, R. (1994). Filial therapy: Strengthening parent-child relationships through play. Sarasota, FL: Professional Resources Press.

VanFleet, R. (1998). Filial therapy: Using parent-child play to strengthen families. Play Therapy Press.

Wall, L (1979). Parents as play therapists: A comparison of three interventions into children's play (Doctoral dissertation, University of Northern Colorado).

Dissertation Abstracts International, 40 5597B.

White, J., Flynt, M., & Draper, K. (1997). Kindertherapy: Teachers as therapeutic agents. International Journal of Play Therapy, 6 (2), 33-49.

Yang, Y. S. (1996). Parental authority in Korean-American parent-teen relationships. Unpublished dissertation, Boston University, Boston.

Yi, S. H. (1993). Transformation of child socialization in Korean culture. Early Child Development and Care, 85, 17-24.

Yuen, T. C. (1997). Filial therapy with immigrant Chinese parents in Canada. Unpublished doctoral dissertation, The University of North Texas. Denton. TX.

Zakreski, J. (1983). Prematurity and the single parent: Effects of cumulative stress on child development. Unpublished doctoral dissertation, University of Virginia, Institute of Clinical Psychology.